



## **No. 1 POLICIES AND PROCEDURES**

The purpose of Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) Policies and Procedures is to provide specific explanations for provisions contained within the contracting provider agreements. This information is intended to supplement and further clarify the reciprocal rights and contractual obligations contained within the contract and the policies established by BCBSKS when services are provided in our service area (the state of Kansas not including Johnson and Wyandotte counties). All existing and future policies and procedures published within BCBSKS publications that are available via the BCBSKS Web site are considered part of the applicable Policy Memo. These publications include newsletters, provider manuals, workshop materials, and periodic update communications. In the event provisions of such BCBSKS publications, policy memos, and/or the provider agreement conflict, the most recently published provision controls.

Any dispute relating to or arising out of the contracting provider agreement and/or BCBSKS' policies and procedures applicable to such agreement, and that is not or cannot be resolved according to the appeal procedures of this Policy Memo, shall be resolved by binding arbitration. Such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association. Arbitration shall be initiated by either party by making a written demand for arbitration upon the other party.

The arbitrator shall have the right to determine his or her own jurisdiction. The arbitration proceeding shall be conducted in Topeka, Kansas, unless both parties agree otherwise. The arbitrator may construe and interpret, but shall not delete from, add to, or modify the terms of the contracting provider agreement and/or BCBSKS' policies and procedures applicable to such agreement. The arbitrator shall have no authority to award extracontractual damages of any kind, including but not limited to consequential, punitive or exemplary damages, and shall be bound by controlling law. The arbitrator shall apply the substantive law of Kansas, without giving effect to any conflict-of-laws principles.

The parties acknowledge that because the contracting provider agreement affects interstate commerce, the Federal Arbitration Act also applies. The parties agree that the decision of the arbitrator shall be final, binding and non-appealable, and that judgment on the arbitration award may be entered by any court of competent jurisdiction. The parties shall share all expenses of the arbitration equally. However, each party shall bear the costs and expense of its own counsel, experts, witnesses, and preparation and submission of its claims and defenses to the arbitrator.

The arbitration process described above shall be available to providers only after exhaustion of all applicable review and/or appeal processes described within these policies and procedures. This exhaustion requirement shall apply to each claim or service in dispute.

## MEDICAL REVIEW PROCESSES

The medical review processes are conducted by the staff of BCBSKS who seek the advice of qualified and, typically, practicing professionals when necessary. A contracting provider agrees to accept review process decisions and to follow the established appeals procedures.

The entire review process itself includes the development of guidelines that relate to specific provisions of members' contracts; the processing of claims based on guidelines and medical records when indicated; the retrospective review of claim determinations; and the appeal process. BCBSKS seeks the advice of clinical professionals at appropriate points throughout the entire review process.

**NOTE:** All pertinent and complete medical records must be provided by the contracting provider within 30 days upon request when records are needed for the initial review of a claim or when records are requested for an audit. The ordering/referring provider shall also provide medical records to the performing provider when requested for the purpose of medical necessity review. Additional documentation that is not a part of the medical record and that was not provided at the time of the initial request will not be accepted. Only records created contemporaneous with treatment will be considered pertinent. Services denied for failure to submit documentation are not eligible for provider appeal, and are a provider write-off.

Medical records are expected to contain all the elements required in order to file and substantiate a claim for the services as well as the appropriate level of care, i.e., evaluation and management service (see Policy Memo No. 2). Complete medical records are expected to contain all the elements required by Section XI. DOCUMENTATION below and by Kansas Administrative Regulation (K.A.R.) 100-24-1, as amended, which is hereby incorporated by reference and made a part of this policy.

Medical records are expected to support the medical necessity for all aspects of patient care, including ancillary services provided on the date of service for which a claim is filed. Each patient record must contain adequate documentation to justify the course of treatment ordered or provided, and reflect the patient's current status and progress during the course of treatment. The intensity of the service billed must be supported by the diagnosis code. Letters/checklists are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be understandable to the reviewer.

If it is determined that the patient services provided by the contracting provider and documented as outlined above, are not medically necessary, the claim is denied and is a write-off to the provider. If the services are requested by the patient after being advised by the provider of the lack of medical necessity and the daily record or patient chart has been documented to that effect and a written waiver is obtained by the provider prior to the service being rendered, charges for the services will be the patient's responsibility.

### I. CORRECTED CLAIM

A request made from a contracting provider to change a claim, (e.g., changing information on the service line, modifier addition, diagnosis correction, etc.) that has previously processed is considered a corrected claim. This excludes claims denied for additional information. The submission of a corrected claim must be received by BCBSKS within the 15-month timely filing deadline.

## II. RETROSPECTIVE CLAIM REVIEWS

The contracting provider shall have the right to a retrospective review of any claim denied in whole or in part. The purpose of a retrospective review is for customer service to determine whether the original adjudication was correct.

- A. All requests for retrospective review, must be submitted (in writing or by phone) to and received by BCBSKS Customer Service within 120 days from the date of the remittance advice.
- B. The provider will be given a written response to the written request for a retrospective review as soon as possible, but no later than 60 days from receipt date. In cases where claims are adjusted, the remittance advice will serve as the written response.

## III. DENIED CLAIMS APPEALS PROCEDURE

Contracting providers may appeal certain pre and post-service claim denials. Only claims denied as not medically necessary may be appealed on the provider's own behalf as set forth in the policies and procedures. The provider may be designated as the member's authorized representative for appeal purposes according to the terms of the member's contract.

**NOTE:** Medical policies including Content of Service (COS) as described in BCBSKS Policy Memos 1-12 or provider's obligations specified in their provider contracts are not considered eligible claims appeals as outlined in Section III. DENIED CLAIMS APPEALS PROCEDURE. Annually, BCBSKS outlines any changes to the Policy Memos and forwards them to providers for their review. Once providers accept these changes, they are part of the provider's contract and therefore not considered for claims appeals. Providers disagreeing with any policies should submit their position and supportive documentation to BCBSKS staff for future consideration.

**Appeals as the Member's Authorized Representative:** Appeals that you can make as the member's authorized representative according to the terms of the member's contract are claims for which the member is financially responsible. When you act as the member's authorized representative, you are not separately entitled to any appeals pursuant to this Contracting Provider Agreement.

**Appeals Pursuant to Contracting Provider's Agreement:** Before initiating the appeal procedures, verify through Section II. RETROSPECTIVE CLAIM REVIEWS inquiry procedures that the claim was correctly adjudicated. After verifying the claim adjudication you may appeal as follows:

**First Level:** Written notification of disagreement highlighting specific points for reconsideration of a claim denied not medically necessary shall be provided to BCBSKS within 180 days from the date of the remittance advice. This notice shall be considered an initial appeal and be forwarded with all pertinent medical records to BCBSKS Customer Service. Medical records submitted with the request for initial appeal will be referred to the appropriate consultant and a determination will be rendered. This decision will be binding unless the provider files a second level appeal within 60 days of notification of such decision.

**Second Level:** Forward a written request to customer service with your letter addressed to the Chief Medical Officer within 60 days following the first level appeal denial notification. The second and final appeal determination shall be made by the Chief Medical Officer. The contracting provider agrees to abide by the second level appeal determination.

All appeal decisions under this agreement must be provided within 60 days of receipt of the provider's request. Any appeals decision not provided within the aforementioned time frames shall be considered as decisions made in favor of the provider and claim payments will be adjusted accordingly.

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

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

#### **IV. POST-PAYMENT AUDITS**

BCBSKS conducts periodic post-payment audits of patient records and adjudicated claims to verify congruence with BCBSKS medical and payment policies, including medical necessity and established standards of care. Post-payment audits can range from a basic encounter audit to determine if the level of care is accurately billed, to a complete audit which thoroughly examines all aspects of the medical record and medical practice. Post-payment audits are performed after the service(s) is billed to BCBSKS and payments have been received by the provider. BCBSKS cannot go back further than 15 months following the date of claim adjudication to initiate an audit. Due to additional time allowed for provider appeals, as outlined in this policy memo, refunds would be applicable after the provider appeals have been exhausted, regardless of the time frame involved. BCBSKS provides education through policy memos, medical policy, newsletters, workshops, direct correspondence, peer consultant medical opinion, and on-site visits.

If medical necessity is not supported by the medical record, BCBSKS will deny as not medically necessary and request refunds. If no documentation is received BCBSKS will deny for no documentation and request refunds. Denials will be a provider write-off.

##### **Post-payment Audit Appeals:**

###### **A. First Level Appeal**

Services denied not medically necessary as a part of the post-pay audit process may be appealed in writing within 30 days of notification of the findings. Written notification of disagreement highlighting specific points for reconsideration should be provided with the appeal. The BCBSKS determination will be made within 30 days of receipt of the appeal.

###### **B. Second Level Appeal**

A provider may request a second and final appeal in writing within 30 days of notification of the first level appeal determination. The second and final appeal is to be submitted to the BCBSKS Chief Medical Officer. The second and final appeal determination will be made by the BCBSKS Chief Medical Officer within 30 days of receipt of the appeal.

When findings reveal issues, which are presently specified in BCBSKS policy memos, 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.

**V. UTILIZATION REVIEW AND MEDICAL NECESSITY**

The contracting provider agreement requires providers to cooperate in utilization review and medical necessity determinations. Utilization review is the process of determining the appropriateness of services rendered to and payments made on behalf of members. Appropriateness of service and payment determinations consist of the following activities:

**A. MEDICAL NEED FOR SERVICES RENDERED**

Medical necessity policy applies to all services rendered to BCBSKS members and includes any services or supplies used to diagnose and/or treat illness or injury. The service should be widely accepted by a peer group of practicing providers, based on scientific criteria and determined to be reasonably safe. Health care professionals should discuss all appropriate treatment alternatives available to patients regardless of benefit coverage limitations. To be determined medically necessary, the service must be consistent with the diagnosis and treatment of the condition; be in accordance with standards of good health care practice; and not be for the convenience of the patient or provider. The following procedures/equipment would be subject to medical necessity and utilization review:

1. Established procedures/equipment of questionable current usefulness in the treatment of a specific condition(s).
2. Procedures/equipment which tend to be redundant when performed/supplied in combination with other procedures/equipment; or procedures/equipment which are unlikely to provide additional medical benefits, or are contradicting to one another.
3. Specific procedures/equipment or patterns of care which vary significantly from a peer group.

**B. PRE-ADMISSION CERTIFICATION & CONCURRENT REVIEW**

Prior to admitting a member to a hospital for elective (non-obstetrical, non-life threatening) inpatient care, medical information will need to be supplied to BCBSKS in order to certify medical necessity. A length of stay will be assigned at the time of pre-certification and will be subject to concurrent review. Concurrent review is the process of obtaining current medical information to review for the medical necessity of a requested extension to the length of stay or course of treatment. Providers will be informed via the member's identification card of the groups involved in pre-admission certification and any specific procedures that are applicable through BCBSKS newsletters.

BCBSKS pre-admission certification and concurrent review activity are conducted in compliance with URAC guidelines. This includes the availability of either the expedited or standard appeal to services denied for medical necessity during the pre-admission certification and concurrent review processes. To initiate an appeal (phone or fax), you must have complete information since the time frame begins with the appeal request. These appeal options are only available prior to claim submission and are subject to time frames as established by BCBSKS, Department of Labor, and URAC. All pre-admission certification appeals for professional and hospital services will be reviewed concomitantly.

### C. OUTPATIENT PRE-CERTIFICATION

Under certain circumstances and upon specific notification, pre-certification may be required for outpatient services/procedures. Contracting providers will be notified 60 days in advance of criteria to identify those situations falling within the scope of this provision.

Pre-certification may also be required for other outpatient services such as home medical equipment and case management, including those services specified by employers, and outpatient procedures which necessitate a greater level of facility care than is usually needed.

Following provider notification, continued failure to complete pre-certification activities will result in a 50 percent Maximum Allowable Payment (MAP) reduction up to \$200 with the member held harmless. Compliance audits will take place on a postpayment basis, which may result in refunds.

### D. CASE MANAGEMENT

Case management is a process that identifies and coordinates alternative treatment plans to enhance care through effective administration of available health care resources in the most cost-efficient manner. The process is accomplished through the development of a treatment plan by the patient or legal representative, the physician, other health care providers, and the BCBSKS case manager.

### E. PREPAYMENT AND DATA ANALYSIS

BCBSKS will identify any trends or patterns of patient care, i.e., through data analysis, which appear inconsistent with overall patterns or trends. Prepayment review will be implemented if attempts to work with the provider have failed to resolve the issue. Specific utilization guidelines may be applied to individual prepay members. Prepayment review means all claims will be reviewed prior to payment and records will be required.

### F. APPROPRIATE PLACE OF SERVICE

The provider agrees to use (to the extent possible) those inpatient, extended care, ancillary services and other health facilities and health professionals which have contracted with BCBSKS. Providers agree to render services to members in the most appropriate and economical setting consistent with the member's diagnosis, treatment needs, and medical condition. Actions taken for providers' lack of compliance will range from provider education to financial assessments and finally requesting contract cancellation. In the event members request referrals to non-contracting providers, providers should have patients sign a statement acknowledging full understanding of the non-contracting referral and the patient's financial responsibilities. The statement should be filed in the patient's chart.

### G. RESOLUTION OF PROBLEMS

Providers agree to work with BCBSKS and other providers of care in the resolution of any utilization or medical review problems that may be identified. Actions taken for providers' lack of compliance will range from provider education to financial assessments and finally contract cancellation.

**H. MEDICAL NECESSITY/UTILIZATION REVIEW DENIALS**

Occasionally BCBSKS does not consider an item or service to be medically necessary. In such situations the item or service becomes a provider write-off. In the few situations where services are known to be denied as not medically necessary (including deluxe items) and the patient insists on the services, the provider must obtain a patient waiver in advance of the services being rendered. (See Section X. WAIVER FORM)

Failure to discuss the above with the patient in advance, document this in the medical record, and obtain the waiver will result in a provider write-off.

**NOTE:** BCBSKS members are not to be billed for services determined to be unnecessary through the medical and utilization review process, per the Contracting Provider Agreements.

**VI. CONTENT OF SERVICE**

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

- Examination of the patient.
- History of illness and/or review of patient records.
- Evaluation of tests or studies (i.e., radiology or pathology).
- Any entries into the patient's records.
- Evaluation of reports of tests or studies earlier referred to another physician for an opinion and subsequently returned for use in the office visit being conducted.
- Advice or information provided during or in association with the visit.
- Case management.
- The prescription of any medicinals, home supplies or equipment during or as a result of the visit.
- The application or the re-application of any standard dressing during a visit.
- Therapeutic, prophylactic, or diagnostic injection administration provided on the same day as an office visit, home visit, or nursing home visit.
- Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.
- Items of office overhead such as malpractice insurance, telephones, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
- Telephone calls and Web-based correspondence are content of service when billed with another service on the same day. Such services are not covered if billed separately and the only service rendered on that day.

Some content of service issues related to specific services and/or procedures are identified throughout the policy and procedure documents.

**NOTE:** All-inclusive procedure codes must be used when appropriate.

A handling fee may be allowed under certain conditions. See Policy Memo No. 7, Radiology and Pathology.

## VII. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Any drug, device or medical treatment or procedure and related services that are experimental or investigational as defined by BCBSKS are non-covered services.

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

- A. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
- B. if Credible Evidence shows that the drug, device or 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 except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
- C. if Credible Evidence shows that the consensus among experts regarding the drug, device or 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 except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
- D. 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 except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Credible evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Research-Urgent shall mean a drug, device, medical treatment or procedure that may be covered (even though otherwise excluded by the contract as experimental or investigational) providing the specified criteria outlined in the contract is met.

Contracting providers shall notify the patient when services to be rendered are considered experimental or investigational and may not be covered under the member's contract. Any patient being billed for services considered experimental or investigational must have a signed waiver in his/her file. The provider must discuss this with the patient in advance, document this in the medical record, and include the GA modifier (waiver on file) on the claim form (electronic or

paper). (See Section X. WAIVER FORM) Failure to discuss and obtain a signed waiver in advance of the service will result in provider write-off. Denied experimental or investigational services are not eligible for appeal.

### **VIII. NON-COVERED SERVICES**

Providers are not reimbursed for professional services they provide to an immediate family member (“Immediate family member” means the husband or wife, children, parents, brother, sister, or legal guardian of the person who received the service) or themselves as specified in the member contract.

There are several categories of services, procedures, equipment and/or pharmaceuticals that may be considered non-covered services when designated by the member’s contract. These denials are billable to the member. (See Section XV. CLAIMS FILING)

### **IX. PATIENT-DEMANDED SERVICES**

- A. If a provider prescribes services that he knows will not be covered because of a lack of medical necessity or the procedure being considered is experimental or investigational and he alerts the patient of the non-coverage, yet the patient still insists on the services, the provider may bill the patient if the request is properly documented and signed by the member. (See Section X. WAIVER FORM)
- B. Providers must obtain a waiver on any mental health consultation, testing, or evaluation that is performed by agreement or at the direction of a court for the purpose of assessing custody, visitation, parental rights, or to determine damages of any kind of personal injury action and if the service is not otherwise medically necessary. To enable the provider to bill a patient for such services, BCBSKS will deny benefits for such services as lacking medical necessity.

### **X. WAIVER FORM**

**NOTE:** The waiver cannot be utilized for services considered to be content of another service provided.

- A. SITUATIONS REQUIRING A WAIVER
  - 1. Medical necessity denials
  - 2. Utilization denials
  - 3. Deluxe features (Applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract)
  - 4. Patient demanded services
  - 5. Experimental/investigational procedures
- B. THE WAIVER FORM MUST BE
  - 1. Signed **prior** to receipt of service.

2. Patient, service, and reason specific.
3. Date of service and dollar amount specific.
4. Retained in the patient's file at the provider's place of business. (The waiver form is no longer required with claims submission. Use the GA modifier for all electronic and paper claims.)
5. Presented on an individual basis to the patients. It may not be a blanket statement signed by all patients.
6. Acknowledged by patient that he or she will be personally responsible for the amount of the charge, to include an approximate amount of the charge at issue.

**NOTE:** If the waiver is not signed **prior** to the service being rendered, the service is considered a contracting provider write-off, unless there are extenuating circumstances.

C. WAIVER FORM (see last page of Policy Memo No. 1)

## XI. DOCUMENTATION

Appropriate documentation of services is an integral part of the payment and/or review process. The contracting provider agrees to keep sufficient records to support claims for reimbursement, documents the medical necessity for the service, and agrees to make available all information necessary to carry out the terms of his/her contracting provider agreement at no charge.

Information, when requested, should be submitted to BCBSKS within 30 days of the request. In the case of typed or electronic medical records, the entry must be authenticated (signed) by the provider at the time of submission. Rubber stamp signatures are not permissible; however, electronic signatures are. The signature must be legible and contain at least the first initial and full last name. This provision does not affect stamped signatures on claims, which remain permissible. Time extensions may be granted on a case-by-case basis; however, any extension must be approved by BCBSKS and will allow BCBSKS additional time for review activities. Certain unusual circumstances as determined solely by BCBSKS require contracting providers to submit medical records to BCBSKS upon request and without advance notice. In these cases, a BCBSKS representative will visit the provider's office during business hours and secure the requested records immediately and without giving prior notice to the provider. The provider agrees to provide these records at the time of request. The member contract gives us the ability to obtain this information without a signed patient release.

Failure to send the requested documentation within the time frame above or providing insufficient or no documentation to determine medical necessity will result in claim denial, and accordingly a provider write-off.

Medical records are expected to contain all the elements required in order to file and substantiate a claim for the services as well as the appropriate level of care, i.e., evaluation and management service (see Policy Memo No. 2). Complete medical records are also expected to contain all the elements required herein and by K.A.R. 100-24-1, as amended, which is hereby incorporated by reference and made a part of this policy.

Medical records are expected to support the medical necessity for all aspects of patient care, including ancillary services provided on the date of service for which a claim is filed. Each patient record must contain adequate documentation to justify the course of treatment provided and reflect the patient's current status and progress during the course of treatment. The intensity of the service billed must be supported by the diagnosis code. Letters/checklists are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be understandable to the reviewer.

## **XII. UNIFORM PROVIDER CHARGING PRACTICES**

Occasionally BCBSKS receives questions about what constitutes a provider's usual charge when a provider offers cash customers a discount and what amount to bill BCBSKS. The term "usual charge" is defined in our Contracting Provider Agreements, but to specifically address this question, our policy is as follows:

- A. Provider discounts or charging practices based upon individual patients' situations (for example: patient hardship or professional courtesy) are acceptable and are not considered the provider's usual charge. If a provider gives a patient a discount for cash, they must bill BCBSKS the same amount.
- B. If a provider gives a lower charge to every patient who does not have health insurance, we consider that lower charge to be the "usual charge."

Because a contracting provider agrees to not bill a BCBSKS member at the time of service, there should never be a circumstance in which a BCBSKS member pays anything other than a deductible, copayment, coinsurance, or non-covered procedure at the time of service. As an additional matter in regard to this point, our payments are timely enough that they are essentially cash for all practical purposes. If we are in fact late with payments, then the remedy is stated under the Prompt Payment law.

- C. Agencies such as community mental health centers and county health departments would be allowed to use a sliding scale for charging practices due to agency regulations.

## **XIII. PURCHASED SERVICES**

When providers bill for PET, CT, or MRI services that were purchased from another provider, they must bill BCBSKS the amount for which the service was purchased.

## **XIV. PROFESSIONAL SERVICES COORDINATED WITH A NON-CONTRACTING PROVIDER**

When a contracting provider uses a non-contracting provider (either in or out-of-state) to perform a portion of a professional service (e.g., professional component, technical component or other technology utilized in the performance of a service), the contracting provider must bill BCBSKS for all services. If the non-contracting provider bills the member or BCBSKS, the contracting provider will be required to hold the member harmless.

## **XV. CLAIMS FILING**

The contracting provider agrees to submit claims to BCBSKS for covered services (excluding "self pay" requests made by the patient as defined within the Health Information Technology for

Economic and Clinical Health (HITECH) Act, Section 13405(a)) rendered to members at the usual charge (normal retail charge for HME suppliers) in the BCBSKS designated format, and to look to BCBSKS for payment except for amounts identified as patient responsibility: copays, coinsurance, deductible, indemnified payment balances and non-covered amounts. The contracting provider agrees to accept payment allowances in all cases once notified of payment determination. Claims must be filed within 15 months of the service date or discharge from the hospital. Failure to do so will result in claims being rejected with members held harmless.

All contracting providers (except as provided in Section XXV.), who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own National Provider Identifier (NPI) or specific performing provider number, if applicable. The name of the ordering provider, when applicable, (including NPI or specific performing provider number, except when exempt by law) must appear on every claim. When applicable, the contracting provider agrees to conduct claim transactions with BCBSKS as standard transactions in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

BCBSKS may encounter a claim that has been submitted using one procedure code which, in the opinion of BCBSKS, is not an appropriate description of the service provided under the circumstances. In such a case, BCBSKS will assign a procedure code which, in its opinion, is appropriate for the service under the circumstance, and will adjudicate the claim based upon such alternative procedure code. BCBSKS may either report payment of the claim under the revised procedure code or under the originally submitted procedure code; in either case, the maximum allowable payment applicable to the revised procedure code shall be the one that applies.

BCBSKS requires providers to report procedures according to American Medical Association Current Procedural Terminology (CPT) and the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) guidelines. However, the proper submission of codes and/or modifiers according to these guidelines shall not imply or create entitlement to health care coverage or reimbursement by BCBSKS for all reported procedures. BCBSKS has sole discretion to determine the applicability of codes and modifiers for reimbursement decisions. Specifically, this discretion includes, but is not limited to, determinations concerning content of service and consideration of modified or add-on codes for additional reimbursement.

For primary procedures, providers should submit the code that most accurately describes the service provided. Add-on codes (as defined by CPT) should not be reported as stand-alone procedures and must be submitted with the primary service in order to be considered for reimbursement. A list of additive codes BCBSKS recognizes for reimbursement is available from your provider representative or the BCBSKS Web site.

Upon implementation of ICD-10-CM, non-specific diagnosis codes (including, but not limited to, Not Otherwise Classified (NOC) and Not Otherwise Specified (NOS) codes) will not be accepted.

If after BCBSKS makes its payment to the provider and a credit balance results from having collected payment from the member, then the provider must refund the credit balance to the member within sixty (60) days from the date the overpayment is identified, unless directed by the member to apply the credit balance to their account for future services.

**XVI. REFUND POLICY**

BCBSKS must request refunds from providers within 15 months from the date of adjudication. Failure to do so will result in the provider being held harmless. Refund requests for fraudulent claim payments and duplicate claim payments, including other party liability claims, are not subject to the 15-month limitation. Providers shall promptly notify BCBSKS upon becoming aware of an overpayment to initiate the refund process.

**XVII. RIGHT OF OFFSET**

BCBSKS will, through auto deduction processes, exercise the right of offset for claims previously paid. This right includes offset against any subsequent claim(s) submitted by the provider, including those involving other members. To accomplish this, BCBSKS will supply providers detailed individual claims information on the remittance advice so amounts can be reconciled efficiently.

**XVIII. SERVICES PROVIDED BY NON-PHYSICIANS AND RESIDENT PHYSICIANS**

- A. All non-physicians, who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own National Provider Identifier (NPI) or specific performing provider number, if applicable. The name of the ordering provider, when applicable, (including NPI, except when exempt by law) must appear on every claim.
- B. A physician may bill for the services of a nurse, other than an ARNP, if there is an employer/employee relationship and the services are supervised by the physician (supervision means the patient recognizes the supervising physician as his/her physician and there is a periodic review of the records by the physician). These services must be an integral part of the physician's professional service, included in the physician's bill, and be of the type that are commonly furnished in the physician's office or clinic.
- C. Independently practicing Advanced Registered Nurse Practitioners (ARNPs) who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own NPI or specific performing provider number. The name of the ordering provider, when applicable, (including NPI, except when exempt by law) must appear on every claim.
- D. Services of a Resident Physician are billed under the attending Faculty Physician's NPI or specific performing provider number if done in connection with the Residency Program.
- E. If the Resident Physician is providing services outside of the Residency Program, all Blue Shield Policy Memos apply and services shall be billed under his/her own NPI or specific performing provider number.
- F. BCBSKS will not pay for any services performed and billed by an independent provider who does not meet applicable state or national licensure registration or certification requirements to perform that service or who is not defined as an eligible provider in the member's contract.
- G. BCBSKS will not pay for outpatient services connected with a nervous and mental diagnosis when provided by an unlicensed provider, or a licensed provider with a licensure other than designated in the member's contract as eligible to provide nervous and mental

benefits. Supervision of an unlicensed provider, a licensed counselor, or one not designated as eligible in the member's contract does not constitute a service being rendered by an eligible provider. The exception to this would be if the service was rendered through a state licensed alcohol or drug abuse treatment facility, a hospital, psychiatric hospital, or a community mental health center. Eligible non-physician psychiatric providers include APRNs/ARNPs, certified psychologists, licensed specialist clinical social workers, licensed clinical marriage and family therapists, licensed clinical professional counselors, and licensed clinical psychotherapists.

## **XIX. LOCUM TENENS PROVIDER**

In situations in which the regular physician is unavailable, a locum tenens can be used to provide a visit/service. The locum tenens must not provide services over a continuous period of longer than 60 days. For situations extending beyond 60 days, BCBSKS must be contacted to discuss billing arrangements.

In billing for services provided by a locum tenens, the claim must be filed using the NPI or specific performing provider number of the provider for whom the locum tenens is substituting and a Q6 modifier must be used. In addition, the medical record must indicate the services were provided by a locum tenens.

## **XX. CONTRACTING STATUS DETERMINATION**

- A. Any entity which provides and/or bills members and/or BCBSKS for health care services which advertises or represents itself to the general public as being owned, controlled, managed, affiliated with, or operated by a contracting provider must also be contracting with BCBSKS unless otherwise permitted by BCBSKS. Failure of such providers to contract with BCBSKS shall be considered cause for termination of the Contracting Provider Agreement in accordance with the Contracting Provider Agreement. This provision is applicable to entities serving members in the same general locale as those served by the contracting provider.
- B. A provider who practices in multiple locations in the same locale must be contracting or non-contracting in all locations.
- C. If the name of the provider set forth in the first paragraph of the contracting provider agreement is a professional association or other legal entity, rather than that of an individual, then the contracting provider agreement applies to all persons within the professional association. Any new providers who join the professional association will be understood to be bound by the contracting provider agreement. The party signing the contracting provider agreement on behalf of the professional association warrants to BCBSKS that such party: (1) has the authority to sign such agreement on behalf of the professional association; (2) shall make the terms of the agreement known to members of the professional association; and (3) shall inform new members of the professional association of the terms of the agreement upon entry into the professional association.

**NOTE:** Certain contracts offered by BCBSKS may offer individual physician options on contract status. Such options are specified by contract language and are offered solely at the discretion of BCBSKS.

The foregoing warranties apply to any person defined as an eligible provider in BCBSKS contracts employed by the individual, professional association or other entity signing the

contracting provider agreement. If such eligible provider is among those identified in Section XXV. TIERED REIMBURSEMENT AND PROVIDER NUMBER REQUIREMENTS hereof, the MAPs applicable to such eligible providers will apply to any services provided by them. If such persons are contracting separately with BCBSKS, until such contract is terminated, then it shall apply rather than these provisions, but if such separate contract terminates, then nonetheless these provisions shall apply with regard to the contracting status of such person. It is the responsibility of the contracting provider or a representative to notify BCBSKS of any changes in practice information, e.g., license status, address, tax ID number, NPI, ownership, individual provider leaving/joining group practice, death of provider, closure of office, etc.

## **XXI. NEW TECHNIQUES AND TECHNOLOGY**

Maximum allowable payments (MAPs) for new techniques, technology, home medical equipment and/or supplies will be based, when possible, on existing procedures/services and comparable value and result. Additional allowances for new techniques, technology, home medical equipment and/or supplies will be considered if there is documented significant improvement in safety or efficacy of patient care.

## **XXII. REIMBURSEMENT AND POLICY CHANGES**

The BCBSKS Board of Directors authorized the following resolution regarding reimbursement changes and staff's authority.

BE IT RESOLVED, that the Board of Directors of BCBSKS, hereby adopts as a policy the delegation of the authority to establish MAPs and to create or change policies and procedures under its contracts with providers of health care services to the executive staff of BCBSKS.

BE IT FURTHER RESOLVED, that the Board of Directors of BCBSKS, hereby adopts as a policy of the corporation the understanding that any requirements for notifying annually each contracting provider at least 150 days in advance of the end of the calendar year of adjustments to the MAP shall not be construed to: (1) require adjustments on the first day of a year; (2) to limit the ability of the corporation, through the authority delegated to staff above, to change MAPs with less notice than 150 days; or (3) to prevent the corporation from changing MAPs, through the authority delegated to staff, more frequently than annually.

BE IT FURTHER RESOLVED, that in making changes in MAP or in creating or changing policies and procedures staff shall provide notice to providers affected thereby at least 30 days in advance of the proposed effective date of such change in MAP or policies and procedures, and such affected providers shall have the ability to terminate their contracts with BCBSKS effective on the proposed effective date of such change rather than abide by such changes in MAP or such policies and procedures.

BE IT FURTHER RESOLVED, that staff shall report to BCBSKS Board of Directors at the same time providers receive notification of changes in MAPs or policies and procedures which staff makes and the nature of such changes. The failure of staff to notify the Board of Directors shall not invalidate such changes to MAPs or policies and procedures.

BE IT FURTHER RESOLVED, that this resolution shall be published as a policy and procedure of the corporation to all contracting providers.

**XXIII. AMENDMENTS TO POLICIES AND PROCEDURES; RIGHT TO TERMINATE CONTRACT**

This provision is intended to supersede and nullify Sections III.A.2. and V.A. of the contracting provider agreement to the extent this provision conflicts with those sections.

**A. Annual Contract Renewal**

As part of its annual provider contract renewal process, BCBSKS notifies providers via U.S. Mail or hand delivery of all changes to its Policies and Procedures and Maximum Allowable Payment schedules at least 150 days prior to the amendments' effective date, which shall be January 1 of the following year. Such amendments must be accepted or rejected in their entirety; acceptance requires no affirmative act by the provider. If the provider finds the amendments unacceptable, the provider agreement may be terminated only by providing BCBSKS written notice of nonrenewal postmarked on or before September 3 of that same year. Such termination shall be effective January 1 of the following year.

**B. Mid-year Amendments**

Occasionally, BCBSKS will amend its Policies and Procedures or Maximum Allowable Payment schedules with mid-year effective dates. When this is necessary, notice of such amendment(s) shall be provided via mail or electronic mail to affected providers at least 30 days prior to the effective date of the amendment(s). If the provider finds the amendment(s) unacceptable, the provider may subsequently terminate their contracting provider agreement by providing BCBSKS with written notification of termination postmarked on or before the effective date of the amendment(s). Termination shall be effective on the effective date of the amendment(s).

**XXIV. ESTABLISHING AND AMENDING MEDICAL POLICY**

The BCBSKS Board of Directors authorized the following resolution regarding establishing and amending medical policy changes and staff's authority.

WHEREAS, the Provider Relations and Medical Affairs Division has identified a need for the ability to establish and amend corporate medical policy in a more expeditious and efficient manner, and

WHEREAS, this division has developed new procedures to establish and amend medical policies more efficiently to better serve Blue Cross and Blue Shield of Kansas members and providers,

BE IT RESOLVED, that the Blue Cross and Blue Shield of Kansas Board of Directors hereby affirms as policy, that when a proposed medical policy does not originate in a Liaison Committee or does not rise to a level of concern requiring review by Liaison, Medical or Dental Advisory Committees, the Provider Relations and Medical Affairs Division is authorized to establish or amend corporate medical policy; and

BE IT FURTHER RESOLVED, that except for non-substantive operational changes, Blue Cross and Blue Shield of Kansas staff shall report all such new policies or amendments to the Board of Directors in a timely fashion. However, failure to do so shall not invalidate any new or amended medical policy.

**XXV. TIERED REIMBURSEMENT AND PROVIDER NUMBER REQUIREMENTS**

BCBSKS has established different MAPs for the same service for the following specialties: Advanced Registered Nurse Practitioners, Physician Assistants, Clinical Psychologists, Licensed Clinical Social Workers, Community Mental Health Centers, Outpatient Substance Abuse Facilities, Chiropractors, Physical Therapists, Certified Physical Therapist Assistants, Occupational Therapists, Certified Occupational Therapy Assistants, Speech Language Pathologists, Licensed Clinical Marriage and Family Therapists, Licensed Clinical Professional Counselors, and Licensed Clinical Psychotherapists. Please review your charge comparison (refer to Section XXXV. CHARGE COMPARISON REPORTS) to determine any write-off amounts.

Eligible providers listed above must obtain an NPI and assure it is included as the performing provider number on all claims submitted before any payment for such claims will be made by BCBSKS. Members may not be billed for services when a claim has not been paid because of the lack of the performing provider NPI.

**XXVI. REIMBURSEMENT FOR NEW PROCEDURE CODES**

Periodically new American Medical Association Current Procedural Terminology (CPT) and the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) codes are published and finalized, usually each December with a January 1 effective date; however, new codes can be added at any time. For those new codes that replace existing codes, BCBSKS will crosswalk the existing MAP to the new code. In the event a new code is established which combines two existing codes, a new maximum allowable payment (MAP) will be established for such new code. For those brand new codes or codes without a Relative Value Unit (RVU), BCBSKS will consider a number of sources, for example: the RVU when applicable, consultants, and input from providers to establish the MAP.

**XXVII. REIMBURSEMENT FOR PHARMACEUTICALS**

Covered pharmaceuticals are reimbursed based on a formula as determined by BCBSKS that utilizes the published average sales price (ASP) or the average wholesale price (AWP). Reimbursement for pharmaceuticals will be reviewed periodically and may be adjusted during the year to reflect changes in the ASP or AWP. A charge comparison report is available upon request.

**XXVIII. REIMBURSEMENT FOR SLEEP STUDY TESTING**

The allowance for sleep testing procedures as outlined by CPT is 100 percent of the MAP for providers board certified in sleep medicine. All other eligible providers receive 60 percent of the MAP.

The allowance for sleep testing procedures performed in Freestanding Sleep Laboratories or Centers is 100 percent of the MAP for those facilities accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC). All other eligible facilities receive 60 percent of the MAP when services are provided in a Freestanding Sleep Laboratory or Center. Services provided in a setting other than a Freestanding Sleep Laboratory or Center will be limited to 50 percent of the applicable MAP for facilities.

**XXIX. REIMBURSEMENT FOR LESSER SERVICES**

When a service performed is considered a lesser service and billed with a "52" modifier, reimbursement may be reduced to an allowance reflective of the service performed.

**XXX. REIMBURSEMENT FOR QUALITY**

In addition to, or in lieu of, the maximum allowable payment (MAP) as referenced elsewhere in any BCBSKS Policy Memo, BCBSKS may establish reimbursement criteria based on quality components to reward providers for meeting specified performance levels. Such criteria and corresponding reimbursement changes will be communicated in advance of the effective date.

**XXXI. ADVERSE EVENTS**

The Blue Cross and Blue Shield list of "Adverse Events" shall automatically include all future CMS adopted "Never Events" that pertain to physicians. The updates become effective immediately upon adoption even if the addition occurs mid-year. The CMS "Never Events" updates do not constitute a change in policy and neither the patient nor BCBS shall pay for the medical errors.

Adverse events A, B, and C are not billable to BCBSKS.

- A. SURGERY PERFORMED ON THE WRONG BODY PART
- B. SURGERY PERFORMED ON THE WRONG PATIENT
- C. WRONG SURGICAL PROCEDURE ON A PATIENT

When one of these three adverse events occurs, no payment will be made to the provider for that error or correction of that error. The patient shall be held harmless and may not be billed for any adverse event. The provider shall refund payments to BCBSKS made for an adverse event if a claim is filed in error. If the surgical error is corrected by a different provider, payment for that procedure will be made.

- D. RETENTION OF FOREIGN OBJECT IN SURGICAL PATIENT

In cases where a foreign object is mistakenly left in the patient during a surgical procedure the following applies:

1. If the same provider also removes the object then no payment for the correcting surgery will be made and the patient will be held harmless.
2. If a provider other than the original provider removes the foreign object, that provider shall receive payment.

The Provider shall cooperate with BCBSKS in initiatives designed to help prevent or reduce such events and ensure that appropriate payments are made with no additional charges incurred for any condition which was not present on admission.

**XXXII. APPLICATION OF CONTRACT**

- A. The conditions of these policies and procedures apply to service benefit programs, indemnity and to self-insured plans administered by Blue Cross and Blue Shield of Kansas, Inc., including those with deductibles, coinsurance and shared payments. For indemnity plans the difference between payment and the MAP allowance can be billed to the patient.

The conditions of these policies and procedures also apply to other entities when services (including services covered by workers compensation) are received within the company service area and Blue Cross and Blue Shield of Kansas, Inc. is involved in the processing of the claim and payment is issued either by Blue Cross and Blue Shield of Kansas, Inc., other Blue Cross and Blue Shield companies/plans or other entities such as insurers or administrators of welfare benefit plans or workers compensation plans.

The conditions of these policies and procedures DO NOT apply to the programs insured and/or administered by Blue Cross and Blue Shield companies/plans when such programs rely upon providers who contract with an entity other than Blue Cross and Blue Shield of Kansas, Inc. for the purpose of establishing reimbursement levels in the company service area. And, in the event the provider is required to submit claims direct to a Blue Cross and Blue Shield company/plan outside the company service area that is adjudicating the claim, the provisions of these policies and procedures do not apply.

- B. When BCBSKS receives and prices a claim which is paid by another entity, such other entity may make payments at variances with those which would be made by BCBSKS if it were adjudicating and paying the claim. In such a case, the provider must bring any such difference to the attention of BCBSKS within 15 months of payment to have such payment corrected.
- C. BCBSKS may review charge/payment records of non-BCBSKS patients to determine contract compliance. The patients' anonymity can be protected by providing information specific to the contract compliance review.
- D. Obligations under the contract with respect to services rendered while contract was in force survive termination of the contract.
- E. When BCBSKS is the secondary insurance payer and the contracting provider has entered into an agreement with the insurance carrier who is the primary payer to accept an allowance which is less than the allowable charge under this contract, then the allowance of the primary insurer shall be considered the allowable charge under this contract for the purpose of that claim. When the allowance of the primary payer is greater than the allowable charge under this contract, the provisions of this contract are applicable.
- F. In circumstances in which a party other than BCBSKS is entitled to the benefits of the Contracting Provider Agreement and these Policies and Procedures, such party may, at its discretion, honor assignments of benefits to providers not contracting with BCBSKS.

### **XXXIII. ACKNOWLEDGMENT OF INDEPENDENT STATUS OF PLAN**

The provider hereby expressly acknowledges its understanding that the agreement to which these policies and procedures apply constitutes a contract between the provider and BCBSKS that the Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans, the Association permitting the Plan to use the Blue Cross and Blue Shield Service Mark, and that the Plan is not contracting as the agent of the Association.

The provider further acknowledges and agrees that he/she has not entered into such agreement based upon representations by any person other than the Plan and that no person, entity, or organization other than the Plan shall be held accountable or liable to the provider for any of the Plan's obligations to the provider created under such agreement. This section shall not create any

additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of such agreement.

#### **XXXIV. ACKNOWLEDGMENT OF BALANCED BUDGET ACT OF 1997**

This contract will terminate if the provider is excluded from participation in any federal health care program, as defined under 42 U.S.C. 1320a-7b(f). Provider agrees to inform BCBSKS of the commencement of any proposed exclusion within seven (7) business days of first learning of it, and to inform BCBSKS immediately upon any such exclusion becoming effective with respect to provider.

#### **XXXV. CONTRACT SCOPE OF SERVICES**

When a provider contracts with BCBSKS, all covered services provided by that provider will be subject to the contract. This means that for covered services, the BCBSKS allowance for that service must be accepted as payment in full, e.g., medical equipment or supplies furnished by the provider.

#### **XXXVI. CHARGE COMPARISON REPORTS**

The provider may request one annual charge comparison report for procedures billed to BCBSKS on behalf of our members. Information included in the annual charge comparison will include services billed and allowed from January to May 31st each year.

#### **XXXVII. PATHOLOGY OR LABORATORY SERVICES**

Anatomical lab must be billed by the provider who renders the service. Clinical lab can be billed by providers in those circumstances where they are sending the specimen outside their office for analysis.

#### **XXXVIII. SPECIAL PROVISION PERTAINING TO PENDED CLAIMS**

The provider contract considers a person a member until such time as there is an indication they are no longer a member. This means that while a member's coverage is in a pending status for lack of payment of premium or notice of change of status, the provider contract continues to apply.

#### **XXXIX. LIMITED PROVIDER NETWORKS**

The overall business climate or some large employer groups may require a reimbursement level lower than that available under the ordinary MAP from BCBSKS. To meet these market needs, BCBSKS may offer an amendment to the Contracting Provider Agreement, or an additional agreement, providing for such lower level of reimbursement. While nothing in these policies will require a provider to accept this additional discount, if a contracting provider fails to accept such addendum or agreement, a contracting provider shall nevertheless accept as payment in full from a member covered under such a program the amounts established as the MAP under the contracting provider agreement. Such provider may collect from such member the deductible, co-insurance, and additional copayments which apply when such person obtains services from providers who have not signed such amendment or additional agreement.

**XL. CAP PROVIDER DIRECTORIES**

BCBSKS makes CAP provider information, including contracting providers' names, available to members on our Web site: [www.bcbsks.com](http://www.bcbsks.com), and to BCBSA for national doctor locator directories.

**XLI. ACKNOWLEDGMENT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY REGULATIONS**

Although BCBSKS does not guarantee the availability of a Web site, if and when a Web site may be made available to contracting providers, the contracting provider shall access such Web site and the information available through it only for the purpose of payment, treatment, and operations as these terms are defined in HIPAA at 42CFR, part 164.

**XLII. ACKNOWLEDGMENT OF K.S.A. 44-1030**

As a provider of services to the State of Kansas and to counties, municipalities and other state governmental units, Blue Cross and Blue Shield of Kansas is required by K.S.A. 44-1030 to observe the provisions of the Kansas Act Against Discrimination, not to discriminate against any person in the performance of work because of race, religion, color, sex, disability, national origin or ancestry, to include the phrase "equal opportunity employer" or a similar phrase in advertisements for employees, and to require in any contracts Blue Cross and Blue Shield of Kansas has with others that such others shall also abide by such provisions, and that if such contractors are found guilty of a violation of the Kansas Act Against Discrimination, such contractors shall be deemed to have breached their contracts with Blue Cross and Blue Shield of Kansas and the contract may be canceled, terminated or suspended in whole or in part. The contracting provider agrees that it shall abide by the foregoing provisions.

**XLIII. MEDICARE ADVANTAGE CLAIMS**

Medicare Advantage (MA) claims 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. For MA claims occurring under a form of coverage offered by a Blue Cross and Blue Shield Plan other than BCBSKS, such other Blue Plan is solely responsible for determining pricing and medical policy (as required by the Centers for Medicare & Medicaid Services (CMS)). A provider's contracting status with 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.



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# LIMITED PATIENT WAIVER

Patient's Name: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Provider Address: \_\_\_\_\_

Provider Number: \_\_\_\_\_

The provider must document in the patient record the discussion with the patient regarding the following service(s).

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

I have been informed and do understand that the charge(s) for \_\_\_\_\_  
(nomenclature/procedure code/appliance)

provided to me on \_\_\_\_\_ (date) will not be covered because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service(s) to be:

- Not medically necessary
- Utilization denials
- Deluxe features (Applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) [the allowance for a standard item(s) will be applied to the deluxe item(s)]
- Patient demanded services
- Experimental or investigational

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS.

**I UNDERSTAND THAT I WILL BE HELD PERSONALLY RESPONSIBLE FOR APPROXIMATELY \$ \_\_\_\_\_.** This amount is an approximation only, based on the service(s) scheduled to be provided.

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

I, \_\_\_\_\_ (witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

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

\_\_\_\_\_  
Date



# Policy Memo

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## No. 2 OFFICE/OUTPATIENT VISIT

For additional information on medical emergency or accident related visits, see Policy Memo No. 3, Outpatient Treatment of Accidental Injuries and Medical Emergencies. Home services may be billed as defined in the American Medical Association Current Procedural Terminology (CPT).

### I. DEFINITIONS

#### PATIENT STATUS

- A. New Patient: A patient who is new to the practice/physician or a patient who has not been seen for three or more years.
- B. Established Patient: A patient who has been previously treated by the practice/physician and for whom records have been established within the past three years.

NOTE: Within a group practice, a consulting physician of a different specialty can bill a new patient office visit if the above criteria have been met. This does not apply to covering arrangements.

- C. Evaluation and Management Levels of Service: Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) follows CPT guidelines for Evaluation and Management service levels.

### II. CONTENT OF SERVICE (See also Policy Memo No. 1)

Usual fees for the professional services for new and established patients are considered to include the following:

- Examination of patient.
- History of illness and/or review of patient records.
- Evaluation of tests or studies (i.e., radiology or pathology).
- Any entries into the patient's record.
- Evaluation of reports of tests or studies earlier referred to another physician for an opinion and subsequently returned for use in the office visit being conducted.
- Advice or information provided during or in association with the visit.
- Case management.
- The prescription of any medicinals, home supplies or equipment during or as a result of the visit.
- The application or the re-application of any standard dressing during a visit.
- Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.

- Examination and/or treatment room
- Items of office overhead such as malpractice insurance, telephones, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
- Telephone calls and Web-based correspondence are content of service when billed with another service on the same day. Not covered if billed separately and the only service rendered on that day.

Some content of service issues related to specific services and/or procedures are identified throughout the policy and procedure documents.

NOTE: All-inclusive procedure codes must be used when appropriate.

A handling fee may be allowed under certain conditions. See Policy Memo No. 7, Radiology and Pathology.

### **III. SERVICE QUALIFYING FOR A SEPARATE PROFESSIONAL FEE IN ADDITION TO AN OFFICE/OUTPATIENT VISIT**

- Charges for injectables may be listed separately from office visit fees and will be considered for payment separately. A separate administration fee will be allowed if no office visit is billed.
- Laboratory examinations and/or diagnostic x-rays.
- Administration of chemotherapy.
- In the case of a combination of office/home visits with physical therapy (modalities and/or procedures), services may be billed separately. The medical necessity of any physical therapy modality and/or procedure in excess of four on the same day must be supported with office records. See CPT for specific reporting of codes.

### **IV. QUALIFICATIONS FOR INDIVIDUAL CONSIDERATION OF UNUSUAL OFFICE/OUTPATIENT VISIT CHARGES**

As with any unusual professional service, atypical office/outpatient visit fees are eligible for individual consideration when supportive medical records accompany the claim using modifier 22.

### **V. OUTPATIENT CONSULTATIONS**

Consultations are services rendered to give advice or an opinion to a requesting physician about a patient's condition and/or management. Medical records must contain documentation of the actual request, the evaluation, and include a copy of the report that is sent to the physician who requested the consultation. Consultations by the same specialty or within the same group are subject to the medical review process. To use the consultation codes, three guidelines apply:

- The request for the consultation must be documented in the patient's medical record.
- The service must be for advice or opinion. While diagnostic work-up or therapy may be ordered and initiated by the consultant, this information must be documented in the record and included in the report to the referring physician.
- A report of the findings and advice must be sent to the referring physician.

When a consultant assumes responsibility for patient care (begins treating the patient, schedules follow-up care, etc.) the additional services are coded as office visits using the appropriate level of Evaluation and Management service for an established patient.

**VI. ADDITIONAL POLICY CLARIFICATION**

- A. Office/outpatient visits provided on the same day as a hospital admission are considered content of the admission. (See In-Hospital Medical [Non-Surgical] Care Policy Memo No. 5.)
- B. BCBSKS allows only one Evaluation and Management service per day per member by the same provider.
- C. Contracting providers agree to assume the responsibility for filing covered office calls when there is payment for a portion of the service.
- D. Observation care (23-hour observation) is allowed for unscheduled medical care. It is not intended for pre and postoperative care of the surgical patient. Only one observation service is allowed unless the 23-hour observation extends into the next calendar day. In this case, a discharge observation would also be allowed. An observation care service is content of service of a hospital admission.
- E. For new surgical patient visits, see Policy Memo No. 9, Section I., Paragraph C-2.
- F. If a physician service is routinely provided to hospice patients, it is not separately billable.



### **No. 3 OUTPATIENT TREATMENT OF ACCIDENTAL INJURIES AND MEDICAL EMERGENCIES**

The contracting provider agrees to submit claims for treatment related to accidental injuries and medical emergencies as covered under the member's contract (see Business Procedure Manual for coverage information).

#### **I. DEFINITIONS**

##### **A. MEDICAL EMERGENCY**

1. Medical emergency means a sudden and, at the time, unexpected onset of a health condition that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.
2. In addition to the conditions listed above, the following conditions will be considered medical emergencies even though they may not directly be life threatening:
  - a. Suspected heart attack
  - b. Unconsciousness

##### **B. ACCIDENTAL INJURY**

Accidental injury means an injury to the body caused solely through external, violent and accidental means.

#### **II. CONTENT OF SERVICE (See also Policy Memo No. 1)**

Usual fees are considered to include both professional fees and the following:

- A. All materials, dressings and medicinals (other than immunizations or injections) furnished by the provider.
- B. Topical or local infiltration anesthesia furnished by the provider.

- C. Evaluation of reports of tests or studies earlier referred to another provider for radiological or pathological opinion.

### III. CRITICAL CARE SERVICES

Critical care includes the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician. Critical care is usually, but not always, given in a critical care area such as the emergency room. Critical care billings beyond the initial care are to be submitted for individual consideration with records. Such reports include the specific nature of the patient's condition, details regarding the services rendered and documentation of the amount of time the physician was in direct patient attendance.

### IV. HOW TO BILL FOR TREATMENT OF ACCIDENTAL INJURIES AND MEDICAL EMERGENCIES IN A HOSPITAL EMERGENCY DEPARTMENT

When the physician is billing for services other than surgery in the treatment of accidental/medical emergency services, reference should be made to the Emergency Department Services section of the CPT for proper code use.

### V. ADDITIONAL POLICY CLARIFICATION

- A. Services in excess of specific payment limitations are subject to individual consideration if requested and supported by medical records.
- B. When made by the same provider, charges for initial non-surgical treatment followed by in-hospital medical care on the same date will not be eligible for payment. In such cases, the hospital medical care charges are considered to include initial temporary palliative or stabilization services. The provider should select the admission code that best represents this combination of services. Contracting providers agree to accept the review process determination in questions of medical necessity.
- C. It is necessary to show the date of injury, the nature of accident, and ICD-9 diagnosis on all accident-related services.
- D. It is necessary to show the date of onset on all services related to medical emergency care.



# Policy Memo

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## No. 4 QUALITY OF CARE

An integral component of the BCBSKS quality improvement program is the evaluation of the health care services rendered to members by contracting providers through medical peer review. Potential quality of care concerns, including adverse events, may be identified and referred by members, providers or other persons who have such information. All such quality of care concerns shall be referred to the manager of the Quality Improvement/Care Management department, who serves as the designated peer review officer for BCBSKS as defined in K.S.A. 65-4915.

### I. QUALITY IMPROVEMENT PROGRAM

An integral component of the quality improvement program is the evaluation of the health care rendered to members by contracting providers through medical record review.

The initial step in improving health care is identification of areas for improvement. Medical record documentation merits special consideration in evaluating the appropriateness and effectiveness of health care.

Pertinent data collected from the medical record is analyzed according to established criteria and implicit medical knowledge by quality improvement staff and peer reviewers. Providers are encouraged to take an active role in the review process, providing additional information and clarification when appropriate.

The second step is to work cooperatively with providers in the development of solutions to the identified problems.

The third step requires recommendations be evaluated to ensure provider's performance meets established standards.

The final step in quality improvement through medical record review is to revise or enhance recommendations which are not improving or maintaining the quality of care as planned.

Emerging patterns of confirmed inappropriate or inadequate care provided by contracting providers are monitored within the quality improvement department. Once a problem or pattern of problems is identified, a Quality Improvement Plan (QIP) may be developed as an educational effort to correct a specific problem relating to the care rendered by contracting providers. All cases in which the quality of care is either questionable or substandard are referred to a physician advisor for evaluation and implementation of a QIP if necessary. If the QIP limits the provider's practice/privileges and the provider does not agree with the determination, the provider may appeal.

A QIP is developed for all providers identified as having a pattern of quality issues. QIPs may be developed for facility, physician, or ancillary providers depending upon the problem focus.

Evaluation of the effectiveness of the QIP will be performed at intervals appropriate to the identified problem or deficiencies, but not to exceed one (1) year.

If, as a result of an adverse quality of care determination by BCBSKS, a QIP is assigned which restricts or suspends a provider's clinical privileges, the provider will be notified of the appeal rights set forth herein. No action will be taken until the provider either exhausts his/her appeal rights or voluntarily waives his/her appeal rights, unless imminent risk of member's health is at stake. If this risk is present, then a temporary action will be implemented awaiting completion of the appeals process.

Prior to institution of any legal proceedings or suit, the appealing provider will utilize the appeal process as outlined.

The appealing provider must submit a letter to the BCBSKS Chief Medical Officer within 30 days of the initial notification of the QIP requesting an appeal. The request should outline why he/she disagrees with the QIP and supply additional information or highlight specific points for reconsideration.

Upon receipt of the outcome of the appeal from the BCBSKS Chief Medical Officer, a letter shall be sent to the appealing provider relaying the final determination. If the determination does not concur with the initial QIP, the plan will be modified or canceled and the provider so notified. If the determination results in continued upholding of the QIP, the appealing provider will be notified of the decision and informed that he/she has exhausted the appeal process.

If the provider continues to disagree with the corrective action plan, he/she may pursue normal remedies of law, if any.

## **II. MEMBER SATISFACTION SURVEY**

Members' perceptions are an essential source of information for BCBSKS. A satisfaction survey is not only a good management tool, but also a key indicator of the quality of care being provided. Surveys may be conducted to comply with performance standards and/or to gain insight into specific issues. BCBSKS is committed to continuous quality improvement and survey results are analyzed to determine areas of strength and areas of concern. Root causes are identified and action plans implemented so improvements can be achieved.

## **III. CARE MANAGEMENT**

BCBSKS has care management initiatives available for our members with diabetes, coronary artery disease, asthma, congestive heart failure, and other chronic medical conditions. The intent of these initiatives is to improve the overall health of our members with chronic health conditions by providing the education, tools, and one-on-one support that may assist members in having a positive impact on their health.

This HIPAA compliant program is physician directed and nurse managed via telephone. Through periodic telephone calls, the nurse case managers can assist in identifying risk factors and offer tools and resources to assist members in managing their chronic health condition.

Members will be contacted by phone or letter and invited to participate in the program. Education material is free of charge, and mailed on an individual basis.

Members will be selected for these initiatives by utilizing the health conditions risk identification tool.

#### **IV. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

According to the HIPAA Privacy Rule, health care providers can disclose protected health information (PHI) to health plans pertaining to credentialing, retrospective review, office record reviews, a Health Information Exchange (HIE), and HEDIS (Healthcare Effectiveness Data and Information Set) data collection for the following types of health care operations:

- A. Quality assurance and quality improvement activities
- B. Accreditation activities (e.g., HEDIS data collection)
- C. Case management, care coordination, and related functions
- D. Disease management
- E. Protocol development
- F. Credentialing provider or health plan performance evaluation
- G. Training
- H. Certification
- I. Licensing

Providers are permitted by HIPAA to disclose PHI to health plans for the above purposes without authorization from the patient when both the provider and health plan have or had a relationship with the patient and the information relates to that relationship.

#### **V. STATE HEALTH INFORMATION EXCHANGE (HIE)**

In the event a Health Information Exchange (HIE) is approved by Kansas Health Information Exchange, Inc., providers are required to provide data to any such health information exchange as requested by BCBSKS.

#### **VI. QUALITY REPORTING AND TRANSPARENCY**

BCBSKS may establish quality initiatives and programs to monitor and report performance results of participating providers, and make available such results in web based and/or written form to the general public, enrolled employer groups, and members.



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## No. 5 IN-HOSPITAL MEDICAL (NON-SURGICAL) CARE

### I. DAILY HOSPITAL MEDICAL SERVICES (NEW OR ESTABLISHED PATIENT)

#### A. INITIAL AND SUBSEQUENT HOSPITAL CARE

Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) will follow the American Medical Association Current Procedural Terminology (CPT) guidelines.

#### B. INTENSIVE CARE UNIT AND CORONARY CARE UNIT (ICU/CCU) DAYS

If it is a provider's customary practice to make a different charge, regardless of the method of payment, for patients confined in ICU/CCU, the fee will be acknowledged. However, such fees are subject to substantiation by the hospital medical records and charge records in the provider's office. Individual consideration should be requested for any period of more than five (5) consecutive days of ICU or CCU care by submitting the CPT code with modifier 22 and attaching medical records.

Billing for ICU/CCU care is based upon the level of subsequent care days as indicated in CPT.

#### C. CRITICAL CARE SERVICES

Critical care includes the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician. Critical care is usually, but not always, given in a critical care area such as the emergency room. Critical care billings beyond the initial care are to be submitted for individual consideration with records. Such reports include the specific nature of the patient's condition, details regarding the services rendered and documentation of the amount of time the physician was in direct patient attendance.

#### D. PLACE OF SERVICE AND LEVEL OF CARE

If patient's admission, continued stay, or level of care is determined to be not medically necessary by pre-certification or claim review, the physician's services will be denied or adjusted.

### II. IN-HOSPITAL CONSULTATIONS

Consultations are services rendered to give advice or an opinion to a requesting physician about a patient's condition and management. Medical records must contain documentation of the actual request, the evaluation, and include a copy of the report that is sent to the physician who requested

the consultation. Consultations by the same specialty or within the same group are subject to the medical review process. To use the consultation codes, two guidelines apply:

The written or verbal request for a consultation may be made by a physician or other appropriate source and documented in the patient's medical record. This must include the specific reason for the consultation.

The consultation service must be advice or opinion and the consultant's findings must be documented in the patient's medical record. While diagnostic work-up or therapy may be ordered by the consultant, it must be documented in the record and included in the reports to the attending physician.

Documentation is the key component because beginning treatment is considered assuming responsibility for care of the patient. When a consultant assumes responsibility for the patient care (begins treating the patient, schedules follow-up care, etc.) the subsequent services are not consults and must be coded as subsequent hospital visits. Any additional consultation visits must be requested by the attending physician and correctly documented to be coded as additional consults.

- A. BCBSKS will follow CPT guidelines for initial consultations.
- B. BCBSKS will follow CPT guidelines for follow-up consultations.
- C. ADDITIONAL CONSULTATION POLICIES
  - 1. One inpatient consultation may be allowed subject to medical necessity concurrence.
  - 2. Additional consultations for multiple diagnoses may be allowed subject to medical necessity concurrence if the physicians are consulting within their defined specialties.
  - 3. Any follow-up visits by a consultant while the attending physician still serves the patient are considered to be concurrent care and should be billed as such (see Concurrent Professional Care, Policy Memo No. 6).
  - 4. A consultation preceding surgery within the usual preoperative timing would be considered within the surgeon's subsequent fee for the surgery, except in the case of a major classified procedure. Providers agree to accept the review process determination in such cases, subject to the rights to appeal and arbitration.
- D. If a physician service is routinely provided to hospice patients, it is not separately billable.



## No. 6 CONCURRENT PROFESSIONAL CARE

Concurrent care takes place when two or more providers render medical and/or surgical services to the same patient during the same period of hospital confinement. Concurrent professional care may be covered if a Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) consultant concurs that supplementary skills by separate providers were medically necessary on the case. BCBSKS reserves the right to review claims as necessary. Contracting providers will write off charges in cases where review consultants determine that concurrent care was not medically necessary (see Policy Memo No. 1 and No. 5). There is one exception: If the patient has been notified by the physician that BCBSKS may deny the service but continues to insist the service be rendered anyway, the physician can bill the patient for these services if the patient was informed in advance and a signed waiver form is kept on file at the provider's place of business. (The waiver form is no longer required with claims submission. Use the GA modifier for all electronic and paper claims.) For further information, see Policy Memo No. 1, Section VIII.

The medical necessity for concurrent care services must be substantiated by the hospital medical records.

### I. INSTANCES WHEN CONCURRENT CARE POLICY APPLIES

- A. Two or more providers rendering medical (non-surgical) services to the same patient on the same day during a common hospitalization period.
- B. Two or more providers rendering any combination of surgical and medical services to the same patient on the same day during a common hospitalization period.
- C. Any case where consultation is followed by daily care by the consulting provider in addition to continuing care by the attending provider.

### II. INSTANCES WHERE CONCURRENT CARE POLICY DOES NOT APPLY

(The services below may be separately charged in all cases, whether surgical or non-surgical.)

- A. Radiology services.
- B. Pathology services.
- C. Diagnostic endoscopies.
- D. Single consultation (one per hospital confinement).
- E. Assistant surgery (when medically necessary).

- F. Administration of anesthesia, other than topical anesthesia.

**III. REPORTING OF CONCURRENT CARE ON CLAIMS**

Diagnoses or conditions requiring concurrent care should be specified and explained to include documentation of medical necessity.



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## No. 7 RADIOLOGY AND PATHOLOGY

### I. DIAGNOSTIC RADIOLOGY POLICY

#### A. WHEN BOTH PROFESSIONAL (PC) AND TECHNICAL (TC) COMPONENTS ARE INCLUDED IN THE CHARGE

The provider's usual fee is considered to include cost of materials and technical operating costs associated with securing the x-ray as well as the fee for interpreting and providing a professional opinion based upon an examination of films which constitute an x-ray study.

##### 1. Definition of "Study"

An x-ray is considered to be the examination of an area of the body as defined by codes and nomenclature. The number of individual x-ray films examined is not considered to affect the fee except as defined in codes and nomenclature.

##### 2. Additional Studies

Additional studies provided on different dates are considered to be eligible for additional usual fees. Coverage of services may vary in programs, but non-covered x-rays are the obligation of the patient. The only exception would be where a review consultant did not concur with the medical necessity for the x-ray study.

##### 3. Multiple MRI and MRA Procedures

- a. When multiple MRI or MRA procedures are performed on the same day and billed as a total component, payment will be made at 100 percent of the primary procedure and 50 percent for each subsequent procedure(s).

Providers may bill PC and TC components separately for MRI or MRA services performed on the same day. Payment will be made at 100 percent of the primary and 50 percent for each subsequent procedure(s) for TC services and 100 percent for all PC services. PC and TC services must be billed on separate lines with the appropriate modifier(s).

- b. NOTE: When radiology procedures are performed on a hospital inpatient, the technical component must be billed by the hospital. The physician may charge for the professional component only. When radiology procedures are performed on a hospital outpatient, the performing provider may charge both professional and technical components only in such cases where the facility

makes no charge to BCBSKS, related to the technical component. In those cases where the institution makes a charge, the provider may bill professional component only, and bill using modifier 26.

- c. If performed by different providers in an office setting, the services (PC/TC) may be billed separately as two lines of service as long as all providers are contracting with BCBSKS. If one provider is not contracting, you are required to bill both PC and TC.

B. WHEN THE PROFESSIONAL COMPONENT ONLY IS CHARGED

The provider's usual professional fee is expected to represent the charge for professional examination and opinion of x-ray films taken at the expense of a facility or institution when the patient is hospitalized as an inpatient/outpatient. The content of professional services within the fee for the study would be subject to the same definition and nomenclature qualifications as explained under "Definition of Study." (above)

C. THE USUAL FEE FOR INTERPRETATION OF AN X-RAY DOES NOT INCLUDE

1. Fees for surgical injection or introduction procedures performed before or during the x-ray examination unless specifically defined by codes and nomenclature as included in the overall service.

When interventional radiology procedures are involved, the professional component may also include injection of contrast media or other surgical intervention.

2. Fees for the administration of anesthesia (other than local infiltration) necessary for performance of special diagnostic x-ray procedures.
3. Fees for an office call which might include treatment of patient either immediately before or following the interpretation of a diagnostic x-ray.

## II. THERAPEUTIC RADIOLOGY POLICY

A. WHEN BOTH PROFESSIONAL AND TECHNICAL COMPONENTS ARE INCLUDED IN THE CHARGE

The provider's usual fee is considered to include the cost of materials and technical operation costs as well as the professional fee for the administration of x-ray and other high energy modalities to include the concomitant office visits and follow-up treatment for 90 days for malignant conditions or 45 days for non-malignant conditions.

B. WHEN THE PROFESSIONAL COMPONENT ONLY IS CHARGED

The provider's usual fee is considered to represent the charge for the administration of radiotherapy provided at the expense of a facility or institution, and follow-up care as outlined under "When Both Professional and Technical Components Are Included in the Charge." (See II. A. above.)

- C. USUAL FEE FOR THERAPEUTIC RADIOLOGY DOES NOT INCLUDE
1. Consultations on need for radiotherapy.
  2. Treatment planning.
  3. Concomitant surgical, diagnostic radiological or laboratory services.

### **III. PATHOLOGY**

A. PATHOLOGY

All anatomic laboratory and cytopathology examinations including gynecological specimens (i.e., Pap tests) must be billed by the entity that performs the entire exam, or a portion of the exam, with the following exception:

When pathology procedures are performed on a hospital outpatient, the provider may charge both professional and technical components only in such cases where the facility makes no charge to BCBSKS related to the technical component. In those cases where the institution makes a charge to BCBSKS for the technical component, the provider should bill the professional component only, using modifier 26.

B. CLINICAL LABORATORY PANEL CODING

When automatable tests are performed on the same day, they may be billed using the appropriate panel or individually. BCBSKS will lump some automatable procedures specified in CPT panels and reimbursement will be limited to the appropriate panel MAP. When an all-inclusive code exists for commonly available clinical tests, the all-inclusive code must be used. Clinical lab can be billed by providers in those circumstances where they are sending the specimen outside their office for analysis.

NOTE: See Obstetrical Services, Policy Memo No. 8, regarding OB laboratory services.

C. THE ANATOMIC OR CLINICAL LABORATORY PROVIDER'S USUAL GLOBAL FEE IS GENERALLY CONSIDERED TO INCLUDE THE FOLLOWING

Cost of equipment and supplies used in performing a test or examination as well as the performance of the test and the professional evaluation and report. A contracting BCBSKS provider may bill for a venipuncture when the specimen(s) is drawn.

The usual fee is not considered to include an office call on the same date of the pathology or clinical laboratory service.

D. HANDLING FEE

To compensate for the cost of materials and services provided when specimens are sent to an outside laboratory, the provider may charge one handling fee per patient per date of service in those cases where he/she does not charge for the test itself. The handling fee must be billed with modifier 22. If the provider bills for the laboratory test, the handling fee is considered content of service of the laboratory charge.



# Policy Memo

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## No. 8 OBSTETRICAL SERVICES

The Obstetrical (OB) Services policy is essentially broken into two sections, normal (non-surgical) OB delivery and surgical OB delivery. Policies governing the content of services for which usual fees are made and qualifications for individual consideration are broken into these two broad categories as follows:

### I. OB SERVICES - NON-SURGICAL CONTENT OF SERVICE

- A. **Total OB care** includes normal antepartum care, delivery (with or without low forceps and/or episiotomy), local anesthesia, and normal postpartum care.
- B. **Antepartum care** includes office visits, routine urinalyses, fetal heart tone monitoring, non-stress testing, stress testing and internal fetal monitoring. (See Section IV. A.)
- C. **Delivery only** includes delivery (with or without low forceps and/or episiotomy) and normal postpartum care.
- D. **Postpartum care** includes hospital care and office visits following delivery.

In cases where the delivering physician provides antepartum care and postpartum care in addition to the delivery, total OB care is to be billed as an all-inclusive charge under the appropriate code.

### II. OB SERVICES - SURGICAL CONTENT OF SERVICE

- A. **Surgical delivery care** includes preoperative care from the admission of the patient to the time of surgical delivery, the surgical delivery itself, and postoperative and postpartum care from the time of surgical delivery through the period of usual hospitalization and customary post-hospitalization ending with the final postpartum examination.
- B. In cases where the delivering physician provides antepartum care and postpartum care in addition to the surgical delivery, total OB care is to be billed as an all-inclusive charge under the appropriate code. However, if a patient has been insured by Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) for less than 240 days, you must bill (using appropriate codes) for those services provided after their effective date of coverage with BCBSKS. The previous insurance carrier (or the patient, if no coverage) would be responsible for services received prior to the BCBSKS effective date.
- C. In cases where different physicians provide the antepartum care and surgical delivery, it will be assumed that the physician performing the delivery provided the post-delivery care. If this is not the case, this should be indicated by using the correct obstetrical CPT code(s).

### III. SERVICES QUALIFYING FOR ADDITIONAL FEES

#### A. OB LABORATORY SERVICES

The usual fee for antepartum care does not include laboratory tests other than urinalyses. Please see Policy Memo No. 7, Radiology and Pathology, Section III. B., Clinical Laboratory Panel Coding.

Specific tests for complicated or unusual prenatal problems may be allowed on the basis of individual consideration and must be documented as to medical necessity.

#### B. OB ANESTHESIA

See Anesthesia Policy Memo No. 12 for more specific information. Local anesthesia is included in the delivery charge.

#### C. IN-HOSPITAL TREATMENT OF COMPLICATIONS

When hospitalization is required for severe complications during either the antepartum or postpartum period, in-hospital medical care fees may be made for the management of the condition. Payment will be subject to medical necessity review of medical records provided to support the additional care and direct attendance.

#### D. UNUSUAL FULL-TERM FEES

Higher than usual professional charges will be considered by consultant review if unusual complications, including threatened miscarriage, occur during the prenatal period, the delivery itself, or during the postnatal period. Approval of such unusual charges is subject to substantiation of medical necessity and the concurrence of the consultant. The contracting provider agrees to accept the consultant's determination in any unusual fee case.

#### E. MULTIPLE DELIVERIES

When multiple births are involved, an additional 25 percent of the maximum allowable payment for the delivery performed will be allowed for each additional child.

### IV. ADDITIONAL POLICY CLARIFICATION

A. Non-stress testing and internal fetal monitoring are considered content of service for the regular attending provider, unless for medically necessary conditions subject to concurrence of the review process determination (unusual conditions must be supported by medical records).

B. Stress testing is subject to substantiation of medical necessity and the concurrence of the review process determination.

C. When outpatient emergency or observation obstetrical care is provided by the patient's regular attending obstetrician, such care is considered to be within the usual and customary fee for total obstetrical care or for antepartum care. However, when emergency care is provided by a physician other than the regular attending obstetrician, the service is eligible for a separate fee.

**V. ADDITIONAL OBSTETRICAL PROCEDURES****A. MISCARRIAGE OR SPONTANEOUS ABORTION**

If a D & C is involved, surgical policy governs. If only medical care is involved, in-hospital medical care policy governs.

**B. THERAPEUTIC ABORTION AUTHORIZED BY LAW**

Surgical policy governs. The usual fee is considered to include the initial examination, office visits up to hospital admission, all standard tests and evaluations, the surgical procedure and final checkup after hospital dismissal.

**C. D & C FOR POSTPARTUM BLEEDING**

Subject to individual consideration with the surgical policy governing.

**D. LABOR MANAGEMENT FEE**

Physicians are eligible for a separate labor management fee when the outcome of a pregnancy results in an emergency cesarean section that is performed by another physician. The physician who provided the antepartum and labor care may bill a separate labor management fee.



# Policy Memo

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## No. 9 SURGERY

### I. GLOBAL FEE CONCEPT

The concept of a global fee for a surgical procedure is a concept under which a single fee is billed and paid for all necessary services normally furnished by the surgeon before, during and after the procedure. Payment may be affected when someone other than the surgeon provides follow-up care as outlined in this policy memo.

To determine the global period for major procedures, count one day immediately before the day of the procedure, the day of the procedure and six weeks immediately following the day of the procedure.

To determine the global period for minor procedures, count the day of the procedure and ten days immediately following the day of the procedure.

To determine the global period for zero day procedures, count the day of the procedure only.

Complete Major and Minor and Zero Day Procedure listings are included in your Business Procedure Manual for your reference and updated as required.

The global maximum allowable payment (MAP) for a surgical procedure includes all services listed in Section A below related to that procedure. These services will not be separately reimbursed. The services included in the global surgical package may be furnished in any setting (e.g., hospitals, ASCs, physicians' offices). Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon.

#### A. COMPONENTS OF A GLOBAL SURGICAL PACKAGE

##### 1. Preoperative Visits

Preoperative visits begin one day before the day of the procedure for major procedures and the day of the procedure for minor and zero day procedures.

##### 2. Intraoperative Services

Intraoperative services (including intraoperative monitoring) are all usual and necessary aspects of a procedure.

3. Moderate (Conscious) Sedation

CPT defines moderate sedation as a drug induced depression of consciousness during which patients respond purposefully to verbal commands, whether alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Costs associated with the medically necessary moderate sedation performed in a separately billing facility are part of the all-inclusive facility MAP and are not reimbursed separately to the surgeon.

Documentation must support the necessity of the anesthesia service and care provided. Blue Cross and Blue Shield of Kansas (BCBSKS) will monitor the appropriate use of the guidelines.

4. Local Infiltration or Topical Application of Anesthesia

No additional fee is acknowledged for these services or supplies. The procedures are considered content of service of the surgical or anesthetic procedure.

5. Complications Following Surgery

All additional medical or surgical services required of the surgeon during the postoperative period of the procedure because of complications which do not require additional trips to the operating room.

6. Postoperative Visits

Follow-up visits during the postoperative period of the procedure that are related to recovery are six weeks for major and ten days for minor procedures. Postoperative visits may be billed for zero day procedures.

7. Post-surgical Pain Management

By the surgeon

8. Supplies

Initial casting, splints, and materials used

9. Miscellaneous Services

Items such as dressing changes, local anesthesia, incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, routine peripheral intravenous lines, and postoperative pain control are considered content of service of the global fee.

Blue Cross and Blue Shield of Kansas, Inc., (BCBSKS) through its Place of Service Differential Program will recognize the additional cost of supplies, personnel and time for **selected** procedures done in the outpatient department of the hospital, ambulatory surgery center (ASC) or office. Such additional charges are to be

included in the surgery fee and are not eligible for reimbursement if itemized separately. It is understood that the fee for these designated outpatient procedures may be higher than those for the same procedure performed on an inpatient basis.

**B. MODERATE (CONSCIOUS) SEDATION**

When provided in an inpatient or outpatient facility, BCBSKS will allow payment for medically necessary moderate sedation to an anesthesia provider, other than the provider of the primary service, who is authorized under state law to administer general anesthesia. Moderate sedation, when performed in an office setting, is considered content of service to the office procedure rendered by the performing provider and will be denied as a provider write-off. (Dental providers please refer to Dental Policy Memo, Section XXXIV.)

**C. SERVICES NOT INCLUDED IN THE GLOBAL SURGICAL PACKAGE**

These services may be paid for separately. In some instances, the procedure code will need to be billed with the appropriate modifier.

1. For major surgeries, the initial consultation or evaluation of the problem by the surgeon to determine the need for the procedure, is allowed as separate from the global. To report, add modifier 57 to the evaluation and management (E/M) code.
2. New patient office or outpatient services (codes 99201-99205) will be allowed on the day of the procedures.
3. Visits unrelated to the diagnosis for which the procedure is performed, unless the visits occur due to complications of the procedure. To report, add modifier 24 or 25 for E/M, or modifier 79 for unrelated procedure or service and include additional supportive diagnoses.
4. Treatment for the underlying condition or an added course of treatment that is not part of the normal recovery from the procedure. To report, add modifier 24 or 25 for E/M, modifier 79 for surgery procedures and additional supportive diagnoses or modifier 22 for individual consideration (see Section VII).
5. Diagnostic tests and procedures, including diagnostic radiological procedures.
6. Clearly distinct surgical procedures during the postoperative period that are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Payment for laser eye surgery; e.g., code 67141 states that the code represents one or more sessions of a procedure. BCBSKS will pay for that service only once during the established period.
7. "78" modifier is used to identify a separate but related procedure being rendered during a postoperative period of another procedure. When appending modifier "78", the original postoperative period ends and a new postoperative period begins, (e.g., major surgery is performed, on day 35 a second related procedure is performed).
8. BCBSKS will deny payment if one of the modifiers (22, 24, 25, 78) is not billed with a service furnished during a global period. These modifiers were established to

facilitate physician billing and processing of services that are not included in the global package.

9. When a service performed is considered a lesser service and billed with a "52" modifier, reimbursement may be reduced to an allowance reflective of the service performed.

## II. PHYSICIANS WHO FURNISH ENTIRE GLOBAL PACKAGE

Physicians who perform the procedure and furnish all of the usual pre and postoperative work bill for the global package by entering the appropriate American Medical Association Current Procedural Terminology (CPT) code for the procedure only.

## III. PHYSICIANS IN GROUP PRACTICE

The following requirements are necessary to permit the BCBSKS payment policy to support the group practice's accounting arrangements.

### A. PHYSICIANS RE-ASSIGNING BENEFITS TO THE GROUP

When different physicians in a group practice participate in the care of the patient, the group must bill for the entire global package. The physician who performed the procedure is shown as the performing physician.

### B. PHYSICIANS NOT RE-ASSIGNING BENEFITS TO THE GROUP

When different physicians furnish the entire postoperative care, the group must bill for the surgical care and the postoperative care as separate line items with the appropriate modifiers.

## IV. PROVIDERS FURNISHING LESS THAN THE FULL GLOBAL PACKAGE

- A. Except for physicians in group practice, there may be occasions when more than one physician provides services included in the global package. The physician who performs the procedure may not furnish the follow-up care. Payment for the postoperative, post-discharge care shall be split evenly between two or more physicians in those instances in which those physicians agree on transfer of care.

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services. Where physicians agree on the transfer of care during the global period, the appropriate modifier should be reported with the corresponding surgical code.

1. 54 for surgery only
2. 55 for postoperative management only
3. 56 for preoperative management only

**B. EXCEPTIONS**

1. When a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate E/M code. The services of a physician other than the surgeon may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case.
2. In some instances, the itinerant surgeon and the physician providing pre and/or postoperative care may make different arrangements than indicated in Section IV.A. above. In such cases, only the itinerant surgeon would submit one global fee for the services to BCBSKS. The other physician would look to the itinerant surgeon for payment of the pre and/or postoperative services. This would allow them to divide the global fee differently than the Medicare percentages, which will normally be used by BCBSKS.

**V. DATE(S) OF SERVICE**

- A. Physicians who bill for the entire global package must enter the date on which the procedure was performed in the "from date of service" field. This will enable us to relate all appropriate billings to the correct surgery.
- B. Physicians who share the out-of-hospital postoperative management with another physician are to submit the "from" and "to" date of service field on the claim to indicate when they assumed and relinquished responsibility for the postoperative care.
- C. If the physician who performed the procedure relinquishes care during the post operative period, he or she need only report the date of the procedure in the "from" field and the date they relinquished care in the "to" field, on the claim.

**VI. REIMBURSEMENT**

BCBSKS will pay each physician direct for the portion of the global surgery services furnished to the insured. Generally the surgeon furnishes the usual and necessary pre and intraoperative services, and also, with a few exceptions, in-hospital postoperative services. In most cases, the surgeon also furnishes the postoperative office services necessary to assure normal recovery from the procedure. Recognizing that there are cases when the surgeon turns over the out-of-hospital recovery care to another physician, percentages have been determined for families of procedures for paying usual out-of-hospital postoperative care if furnished by someone other than the surgeon.

**VII. UNUSUAL CIRCUMSTANCES**

Surgeries for which the services performed are significantly greater than usually required may be billed with the 22 modifier added to the CPT code for the procedure. Please provide:

- A. A concise statement about how the service differs from the usual, and
- B. An operative report or any other medical record documentation necessary to explain or describe the patient's condition with the claim.

**VIII. DISCHARGE PROCEDURES BY SOMEONE OTHER THAN THE SURGEON**

When a physician other than the surgeon performs discharge procedures at the request of the surgeon, these services are considered content to the global fee, and no additional payment will be made. BCBSKS will assume that discharge services are related to the procedure.

**IX. ADDITIONAL POLICY CLARIFICATION**

Up to 20 percent of the initial surgeon's fee may be allowed for postoperative bleeding for cardiac pulmonary bypasses and after use of the heart/lung machine. Other surgical postoperative complications may be eligible subject to individual consideration.

IMPORTANT NOTE: Other policies exist with respect to specific surgical situations. Providers specializing in surgery should check with the BCBSKS professional field representative whenever detailed questions arise.

**X. ADVERSE EVENTS**

The Blue Cross and Blue Shield list of "Adverse Events" shall automatically include all future CMS adopted "Never Events" that pertain to physicians. The updates become effective immediately upon adoption even if the addition occurs mid-year. The CMS "Never Events" updates do not constitute a change in policy and neither the patient nor BCBS shall pay for the medical errors.

Adverse events A, B, and C are not billable to BCBSKS.

- A. SURGERY PERFORMED ON THE WRONG BODY PART
- B. SURGERY PERFORMED ON THE WRONG PATIENT
- C. WRONG SURGICAL PROCEDURE ON A PATIENT

When one of these three adverse events occurs, no payment will be made to the provider for that error or correction of that error. The patient shall be held harmless and may not be billed for any adverse event. The provider shall refund payments to BCBSKS made for an adverse event if a claim is filed in error. If the surgical error is corrected by a different provider, payment for that procedure will be made.

**D. RETENTION OF FOREIGN OBJECT IN SURGICAL PATIENT**

In cases where a foreign object is mistakenly left in the patient during a surgical procedure the following applies:

1. If the same provider also removes the object then no payment for the correcting surgery will be made and the patient will be held harmless.
2. If a provider other than the original provider removes the foreign object, that provider shall receive payment.

The Provider shall cooperate with BCBSKS in initiatives designed to help prevent or reduce such events and ensure that appropriate payments are made with no additional charges incurred for any condition which was not present on admission.



# Policy Memo

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## No. 10 ASSISTANT SURGERY

Assistant surgery is considered to be only those services provided at the operating table by the surgical assistant. Being available to assist does not constitute assistant surgery (see important note below regarding non-physician assistant surgeons).

### I. MEDICAL NECESSITY GUIDELINES

- A. Assistant surgery is covered by Blue Cross and Blue Shield of Kansas, Inc., (BCBSKS) if it is customarily required in conjunction with the surgical procedure due to medical necessity, and if it would customarily be billed to the patient regardless of his/her method of payment.
- B. The use of more than one assistant surgeon is subject to individual consideration and covered only upon substantiation of medical necessity. Contracting providers agree to accept the review process determination in such cases.

### II. REIMBURSEMENT

Assistant surgery reimbursement is based on a percentage of the surgical maximum.

### III. PREOPERATIVE AND POSTOPERATIVE CARE

With respect to assistant surgeons who provide pre and postoperative care when the operating surgeon is in the "traveling" (itinerant) category, preoperative and postoperative care may be allowed in addition to assistant surgery if this is explained in the submission of claims. In these instances, preoperative and postoperative services should be itemized separately from the assistant surgery fee. In some cases, the itinerant surgeon will make his/her own arrangements for pre and postoperative care. In those cases, the physician should look to the surgeon for payment.

### IV. NON-PHYSICIAN ASSISTANTS

BCBSKS will make payments for assistants only for those persons (Physician Assistants and Advanced Registered Nurse Practitioners) licensed and authorized by Kansas law. BCBSKS will **not** make payments for services of a registered nurse or other non-physicians (including Certified Surgical First Assistants) assisting at surgery.

**IMPORTANT NOTE REGARDING DENIAL OF BENEFITS:** Denial of benefits for the services of an assistant surgeon is the result of the BCBSKS review process determination. In the event benefits are denied, contracting providers agree to forgive charges to BCBSKS members. Exception: If the patient has been informed such services may not be covered but requests the services be furnished,

the patient may be charged for the service even though it was not considered medically necessary. A waiver must be signed by the member to support such requests (see Policy Memo No. 1, Section X. WAIVER FORM).

A list of those procedures for which an assistant surgeon is not normally reimbursed is found in your BCBSKS Business Procedure Manual.



## **No. 11 MULTIPLE SURGICAL PROCEDURES**

This policy applies when more than one surgical (open, scope, or other) procedure is performed by one or more providers on the same patient on the same date. Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) requires providers to report procedures according to American Medical Association Current Procedural Terminology (CPT) and the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) guidelines. However, the proper submission of codes and/or modifiers according to CPT and/or HCPCS guidelines shall not imply or create entitlement to health care coverage or reimbursement by BCBSKS for all reported procedures. BCBSKS has sole discretion to determine the applicability of codes and modifiers for reimbursement decisions. Specifically, this discretion includes, but is not limited to, determinations concerning content of service and consideration of modified or add-on codes for additional reimbursement.

### **I. MULTIPLE SURGICAL PROCEDURES WHEN PERFORMED BY ONE PROVIDER**

The policy, in respect to multiple surgical procedures performed by the same provider, is based upon the premise that usual charges for multiple procedures will normally not equal the sum of the charges for each procedure, if these were done independently. This is because there would be a common episode of preparation and follow-up. The procedure with the greater BCBSKS maximum allowable payment (MAP) will be allowed at 100 percent of the usual professional charge up to the MAP. For other procedures performed at the same setting, the usual professional charge, up to 50 percent of the MAP, will be allowed, except as otherwise specified in this policy.

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

### **II. ENDOSCOPIES, ARTHROSCOPIES, AND OTHER SCOPE PROCEDURES**

For two or more surgical scope procedures that involve multiple compartments or sections of the same anatomic area (including but not limited to joints, sinuses, and abdominal, chest, pelvic, and cranial cavities), only the procedure with the highest BCBSKS MAP will be reimbursed; other procedures shall be considered content of service. Exceptions based on unusual clinical intensity and/or use of physician resources are also available on a claim-by-claim basis; such claims will

only be considered for additional reimbursement if Modifier 22 and appropriate supporting records are submitted with the original claim.

- A diagnostic scope is incidental to another diagnostic scope or a surgical scope (including biopsy).
- A diagnostic scope “with” or “without” biopsy is incidental to an open surgical procedure in the same anatomical area.
- A diagnostic scope is incidental to a diagnostic scope with biopsy unless the verbiage distinguishes the procedure as “with biopsy” versus “without biopsy.”
- Incidental relationships are applied to endoscopic, arthroscopic, and other scope procedures based on the following:
  - complete versus partial
  - with versus without
  - extensive versus limited
- An endoscopic, arthroscopic, or other scope procedure and open surgical procedure in the same anatomic area will not both be reimbursed.
- If an open surgical procedure and an endoscopic, arthroscopic, or other scope procedure accomplish the same result, the clinically more intense procedure is recommended for reimbursement. The comparable procedure is found incidental.
- For some endoscopic, arthroscopic, or other scope procedure assisted, open surgical procedures performed on the same anatomic area during the same operative session, separate reimbursement will be allowed based on additional time, skill and physician resources.

### III. OTHER POLICY PROVISIONS

- A. A provider shall not charge for procedures to correct iatrogenic events resulting from medical or surgical treatment by that provider.
- B. Certain procedures have individually established payment guidelines that do not follow this policy. Those procedures include the codes in which the code itself inherently describes multiple services or those recognized by BCBSKS as additive codes.
- C. When multiple procedures are performed by more than one provider, see Policy Memo No. 6, Concurrent Professional Care.



# Policy Memo

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## No. 12 ANESTHESIA

### I. DESCRIPTION

Anesthesia services consist of the administration of an agent in one of the following types of anesthesia:

- A. General anesthesia – loss of ability to perceive pain associated with loss of consciousness produced by intravenous infusion of drugs or inhalation of anesthetic agents.
- B. Regional anesthesia – use of local anesthetic solutions to produce circumscribed areas of loss of sensation. This includes nerve blocks, spinal, epidural, and field blocks. Epidural anesthesia is produced by injection of local anesthetic solution into the peridural space.

### II. TIME OF ADMINISTRATION

Anesthesia time begins with the initial administration of anesthetic agents by the anesthetist/anesthesiologist and ends when the anesthetist/anesthesiologist is no longer in personal attendance. The time of anesthesia administration and the CPT anesthesia codes are required on all claims to ensure proper payment.

### III. CONTENT OF SERVICES WITHIN USUAL ANESTHESIA FEE

The usual professional charge for anesthesia includes the following services:

- A. Preoperative or postoperative administration and monitoring of anesthetic or analgesia administration.
- B. Administration of drugs, fluids, or blood incidental to the anesthesia.
- C. Preoperative and postoperative monitoring and/or visits to the patient (including consultations).
- D. Monitoring of sedation for cardiac catheterizations and PTCAs is done by the cardiologist and facility personnel, therefore, separate reimbursement is not provided. If intraoperative monitoring is required and performed during a surgery, BCBSKS will content the service into the all-inclusive surgical MAP.

- E. Local Infiltration or Topical Application of Anesthesia.

No additional fee is acknowledged for these services or supplies. The procedures are considered content of service of the surgical or anesthetic procedure.

#### **IV. SURGICAL PROCEDURES AND NERVE BLOCKS PERFORMED BY THE SAME ANESTHESIA PROVIDER**

Surgical procedure(s) (e.g., arterial & CVP lines) billed with nerve blocks will be paid according to multiple procedure guidelines at full for the procedure with the greatest value and all others are paid at one half.

#### **V. METHOD OF DETERMINING THE MAXIMUM ALLOWABLE PAYMENT (MAP)**

##### **A. PROFESSIONAL ALLOWANCES**

Professional allowances for general anesthesia are determined as follows:

1. Anesthesia base points of the CPT/American Society of Anesthesiologists (ASA) codes, plus
2. One point per each 15 minutes of administration.

NOTE: The above are multiplied by the Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) anesthesia conversion factor.

##### **B. ANESTHESIA FOR MULTIPLE SURGICAL PROCEDURES**

Allowance determined by:

1. Using the CPT code with the highest base value allowed.
2. Payment of one unit of time per 15 minutes administration.

#### **VI. RELATED POLICIES**

##### **A. UNUSUAL CASES**

When the condition of the patient relative to the surgical procedure to be performed is such as to imply an unusual risk, consideration of an unusual fee may be provided. In such cases, it is necessary to use Modifier 22 and send medical information that will substantiate the case and document direct attendance. It is acknowledged that unusual detention with the patient is eligible for additional time charges. Contracting providers agree to accept the review process determination in such cases.

##### **B. REGIONAL ANESTHESIA**

1. When administered by the surgeon or assistant surgeon, payment may be allowed. However, if an anesthesia provider monitors the patient following the regional block, the surgeon or assistant surgeon relinquishes the right to bill for the regional block.

2. A claim for epidural infusion for pain management will be subject to the review process prior to payment.
  - a. If the epidural catheter is placed for the purpose of anesthesia and remains in place for postoperative pain management or local anesthetics, placement of the catheter will be considered content of service of the anesthesia.
  - b. If the epidural catheter is placed solely for postoperative purposes (i.e., postoperative anesthetic or pain control), even if general anesthesia or other than epidural is performed, the catheter placement will be paid.
  - c. Daily hospital management of epidural drug administration by an anesthesia provider may be paid when either options a. or b. apply. However, if the pain management is accomplished by the surgeon, the pain management is considered content of the service for the surgeon.
  
3. OB Epidural Guidelines
  - a. Epidural placement, monitoring and delivery anesthesia will be reimbursed using the appropriate CPT neuraxial labor analgesia/anesthesia codes for vaginal and cesarean deliveries.
  - b. Anesthesia time should be reported as total minutes of documented direct care for anesthesia administration.
  - c. BCBSKS will reimburse one unit for every hour of documented direct attendance monitoring.
  - d. If the direct attendance exceeds 15 minutes in any given hour, then there must be documentation in the patient's medical record to support the medical necessity for the additional time.
  - e. Total time from placement to removal of epidural SHOULD NOT be billed, but rather bill the minutes that the anesthesia provider is in direct attendance with the patient.
  - f. When a vaginal delivery with epidural anesthesia is expected but results in a C-section, you should bill 15 minutes per hour of documented direct care epidural anesthesia using the appropriate CPT anesthesia code. Use the normal process for reporting general anesthesia time using the appropriate CPT anesthesia code for the C-Section.
  - g. BCBSKS will reimburse 20 units maximum without review for vaginal deliveries and 25 units maximum for C-section.
  
4. Nerve blocks administered on the same day as an anesthesia service will be paid at 50 percent and the anesthesia service paid in full.

### C. MONITORED ANESTHESIA SERVICES

Monitoring of sedation by an anesthesia provider for gastrointestinal endoscopies, CT scans, MRIs, cardiac catheterizations, and PTCAs is generally considered not medically necessary. BCBSKS will allow payment for inpatient or outpatient facility services when provided for

other procedures when billed by an anesthesia provider capable of initiating general anesthesia should it be needed.

The monitored anesthesia services must be billed with modifiers:

QS – Monitored anesthesia care service

G8 – Monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure

G9 – Monitored anesthesia care for at-risk patient – patient has a history of severe cardiopulmonary disease

Documentation must support the necessity of the anesthesia service and care provided. BCBSKS will monitor the appropriate use of the guidelines.

#### D. UNUSUAL ANESTHESIA

Unusual anesthesia is applicable only to anesthesia for upper gastrointestinal or lower intestinal endoscopic procedures.

1. Claims for this level should be billed with modifier 23 describing unusual anesthesia.
2. Reimbursement to a CRNA or physician capable of starting anesthesia will be the lesser of your charge up to the MAP.

#### E. MODERATE (CONSCIOUS) SEDATION

CPT defines moderate sedation as a drug induced depression of consciousness during which patients respond purposefully to verbal commands, whether alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

When provided in an inpatient or outpatient facility, BCBSKS will allow payment for medically necessary moderate sedation to an anesthesia provider, other than the provider of the primary service, who is authorized under state law to administer general anesthesia. Moderate sedation, when performed in an office setting, is considered content of service to the office procedure rendered by the performing provider and will be denied as a provider write-off.

Documentation must support the necessity of the anesthesia service and care provided. BCBSKS will monitor the appropriate use of the guidelines.

#### F. MEDICAL DIRECTION

The medical direction or supervision of CRNAs is not a separately reimbursable service. BCBSKS will only reimburse one provider for an anesthesia procedure.