

July 2006

CAP

Competitive Allowance Program 2007 CONTRACT

The mission of Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) is to excel at meeting our customers' health and benefit needs. The cost and affordability of health insurance remains a major concern of our members. Affordability of health care continues to be impacted by a number of factors: escalating medical use, increasing trends, demand for services, aging population, technological advances, and shrinking population in the BCBSKS service area, just to name a few.

Our administrative expenses are 7.82 percent of premium income, as of April 30, 2006. We know of no other insurance company that rivals this low percentage. Our company continues to focus on maintaining low corporate administrative costs with prompt service to our members and providers.

Local enrollment now stands at 678,960 members. BCBSKS addresses the health care needs of 875,628 Kansans, including BlueCard. In the last twelve months we have added 64,412 members, which is a significant gain in membership. Financially, BCBSKS is in a solid position with positive contribution to reserves. Strong policyholder reserves allow us to meet the health care coverage needs of our members, make available valuable Web-based services, prepare for contingencies/disasters, and adhere to state regulations and requirements of the Blue Cross and Blue Shield Association, while controlling administrative costs.

As a contracting provider, you continue to receive excellent business services which bridge the gap between the delivery of health care services and the financing of prepaid health care benefits for your patients. Business services provided by BCBSKS creating the most significant value to you as a contracting provider include:

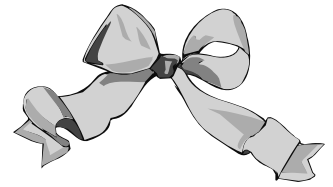
- Local member contracts structured to allow 100 percent of the maximum allowable payment (MAP) for participating CAP providers and 80 percent of the MAP to non-contracting providers.
- Direct payment from BCBSKS, which minimizes your collection efforts and increases cash flow. (Please note: Non-contracting providers do not receive direct payment, nor is assignment of benefits allowed.)
- Web site (www.bcbsks.com) available at your convenience, which improves your office efficiencies and maximizes your employee resources.
 - Secured services to include detailed claims payment information, member eligibility, remittance advice, and provider enrollment information.
 - Other services including training modules, newsletters, manuals, policy memos, and medical policies/guidelines.
- Detailed claims payment information provided to both you and the member explaining their financial responsibilities.
- Contracting providers' names made available to BCBSKS members through a number of sources, including the Internet, employer groups, and other contracting providers for referral purposes, which increases the potential for new patients.
- A dedicated field staff available to visit your office to address any operational issues.
- Periodic workshops held by professional relations staff, which deliver continuous training for new and experienced medical assistant staff to help update them on new administrative procedures to ensure timely claim payments.
- Providers and their staffs having access to professional relations hotline personnel to answer policy questions or obtain assistance with claim coding questions.

If you have questions regarding any information contained in this letter, please contact your professional relations representative or the hotline at 1-800-432-3587 (in Topeka, 785-291-4135).

Your continued contracting status is important to our members and many of your patients. If for any reason you feel unable to continue your contract, please contact me directly (Fred Boston, 785-291-8831). If you feel you cannot accept this contract offering and choose to terminate your provider contract, you must forward your written correspondence postmarked no later than midnight, **September 1, 2006**. Please mail it to: Fred Boston, Director, Professional Relations, CC 480E1, 1133 S.W. Topeka Blvd., Topeka, KS 66629.

Blue Ribbon News

- Blue Choice enrollment gains 57,479 members, with enrollment totaling 446,321 members as of May 31, 2006. This program does not utilize referrals and members may seek care from the CAP providers of their choice.
- 98 percent of Kansas physicians are CAP contracting.
- 93 percent of all professional providers are CAP contracting.



Trends

- Consumer-directed health options are available from BCBSKS.
- Technology costs and prescription medication continue to contribute significantly to increasing premiums.
- Some employers are continuing to carve out benefits and evaluate high deductible programs.
- More providers are electronically connected to BCBSKS to effectively complete daily operational health care administration.
- Wellness programs and healthy lifestyles are of interest to consumers.



REIMBURSEMENT CHANGES

Major reimbursement changes include expansion of the site of service program implemented in 2006, increasing most CPT codes and eliminating our bundling rules for clinical laboratory panels.

On June 22, 2006, the BCBSKS Board of Directors met and approved 2007 reimbursement and Policy Memo changes. Charge comparisons reflecting reimbursement changes are available by contacting your professional relations representative or the hotline at 1-800-432-3587 (in Topeka, 785-291-4135).

Please review all materials immediately, as the September 1, 2006 deadline is fast approaching. The following is a brief overview of reimbursement changes reflected in your charge comparison and a summary of policy memo changes:

- MAPs for all evaluation and managements codes will increase; for example, 99213 will be \$59.28.
- The MAPs for most CPT codes have increased.
- Site of Service will be expanded for additional CPT codes (see enclosed list).
- Clinical lab MAPs will be frozen or adjusted to accommodate removal of bundling logic. As a result, if you do all tests within a panel, you should bill the panel CPT code. If you only do part of the tests in a clinical laboratory panel, you should bill the individual CPT codes and we will reimburse them separately.
- Reimbursement for some individually selected HME services will be adjusted, either up or down.
- The anesthesia conversion factor will increase to \$51.25.
- MAPs for specialized imaging (CT, MRI/MRA, PET) will be frozen. General diagnostic radiology allowances will be increased.

Again, the above changes are reflected in your charge comparison for services billed during the first five months of 2006.

Contact Information

Professional Relations Staff	Location	Phone Number	
Fred Boston, Director	Topeka	1-800-432-0216 ext. 8831	(785) 291-8831
Rusty Doty, Manager	Topeka	1-800-432-0216 ext. 8206	(785) 291-8206
Sue Dunaway	Topeka	1-800-432-0216 ext. 8207	(785) 291-8207
Diana Evans	Topeka	1-800-432-0216 ext. 8716	(785) 291-8716
Cheri Iarossi	Topeka	1-800-432-0216 ext. 8651	(785) 291-8651
Vikki Lindemuth	Topeka	1-800-432-0216 ext. 7724	(785) 291-7724
Professional Relations Hotline	Topeka	1-800-432-3587	(785) 291-4135
Debra Meisenheimer	Hutchinson	(620) 663-1313	
Velda Fresquez-Gray	Wichita	1-800-432-0216 ext. 1674	(316) 269-1674
Denny Hartman	Wichita	1-800-432-0216 ext. 1674	(316) 269-1674
Gwen Nelson	Dodge City	(620) 225-0884	

Important Information

Following is a summary of changes to Blue Shield policies and procedures for 2007. A complete set of policy memos will be available December 2006 in the provider publications section of www.bcbsks.com.



Policy Memo No. 1

Medical Review Processes

The third paragraph was reworded to include record requests for audits. The fifth paragraph was reworded specifying “complete” medical record. The last paragraph was reworded for clarity.

The medical review processes are conducted by the staff of BCBSKS who seek the advice of qualified and practicing professionals related to medical necessity. 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 practicing professionals at appropriate points throughout the entire review process.

NOTE: All pertinent and complete medical records must be provided by the contracting provider when records are needed for the initial review of a claim or when records are requested for an audit. Additional information that is not a part of the medical record or information that was not provided at the time of the initial request will not be accepted after the review has been completed. Only records created contemporaneous with treatment will be considered pertinent.

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).

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 need 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.

Sections I. & II. Retrospective Claim Reviews & Denied Claim Appeal Procedure

Using existing time frames, the entire review process can take up to one year and three months. Medical review staff felt this was too lengthy and shortened the time frames for BCBSKS to respond and for providers to initiate a retrospective claim review and claims being appealed.

I. 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, including corrected claims, must be submitted in writing to and received by BCBSKS Customer Service within 120 days of the adjudication.
- B. The provider will be given a written response to the 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.

II. 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 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 II. DENIED CLAIMS APPEALS PROCEDURES. 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 Agreement: Before initiating the appeal procedures, verify through I. 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 original claim adjudication date. 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 re-appeals the decision within 60 days of notification.

Second Level: Forward a written request to customer service, with your letter addressed to the vice president of medical affairs. The final appeal determination shall be provided by the vice president of medical affairs. The contracting provider agrees to abide by the final determination in the appeals process.

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.

Section V. Content of Service

The reference to content of service for venipuncture to an E&M was removed since we now allow separate reimbursement for venipuncture.

Section IX. Waiver Form

Wording was added clarifying deluxe waivers are applicable to deluxe orthopedic and prosthetic appliances as specified in the member contract.

IX. WAIVER FORM

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

A. SITUATIONS REQUIRING A WAIVER

3. Deluxe features (Applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract.)

Section X. Documentation

Language was added clarifying that failure to send requested records to determine medical necessity will result in claim denials.

X. 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 need 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. The member's contract gives us the ability to obtain this information without a signed patient release. If there is insufficient information to determine medical necessity, claims will ultimately be a provider write-off or refund. Failure to send the requested documentation within the time frame will also result in claim denials for lack of medical necessity.

Section XVII. Services Provided by Non-Physicians and Resident Physicians

Wording was added to paragraphs A. & C. to include the National Provider Identifier number.

XVII. 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, should bill their charges to BCBSKS under their own specific performing provider number or National Provider Identifier (NPI) if applicable. The name of the ordering provider, when applicable, (including UPIN or NPI, except when exempt by law) must appear on every claim.

- C. Independently practicing Advanced Registered Nurse Practitioners (ARNPs) who are providing services as defined in their Kansas licensure or certification, should bill their charges to BCBSKS under their own specific provider number. The name of the ordering provider, when applicable, (including UPIN or NPI, except when exempt by law) must appear on every claim.

Section XXIV. Reimbursement for Sleep Study Testing

Wording was removed referring to specific CPT codes for sleep testing. Also, BCBSKS no longer reimburses at 100 percent of MAP those providers who have only applied for AASM certification. All providers are required to attain AASM certification to receive 100 percent of the MAP.

XXIV. REIMBURSEMENT FOR SLEEP STUDY TESTING

The allowance for sleep testing procedures as outlined by CPT is 100 percent of the MAP for providers who are board certified in sleep medicine. All other eligible providers receive 60 percent of the MAP. The allowance for sleep testing procedures for Freestanding Sleep Laboratories or Centers is 100 percent of the MAP for those providers who are accredited by the American Academy of Sleep Medicine (AASM). All other eligible providers receive 60 percent of the MAP.

Section XXXVII. Medicare Advantage Claims

Language was added clarifying Medicare Advantage programs offered by other Blue Plans.

XXXVII. 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 MA 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.

Last Page, Waiver Form

Wording was added clarifying deluxe waivers are applicable to deluxe orthopedic and prosthetic appliances as specified in the member contract.

Policy Memo No. 4

Section VI. Member Concern and Complaint

Wording was modified specifying only written inquiries and removing the ability for a member to request a formal grievance hearing.

VI. MEMBER CONCERN AND COMPLAINT

BCBSKS recognizes that from time to time members may encounter situations where the performance of BCBSKS or their PCP does not meet their expectations. When this occurs, the member has the right to direct an inquiry to the attention of BCBSKS management. An inquiry must be received in writing. It is the policy of BCBSKS to promptly and fairly consider all inquiries of its members. BCBSKS monitors the number and type of complaints made by members, and monitors trends and patterns.

Complaints are reviewed on an ongoing basis. The member's PCP may be contacted by their professional relations representative for additional information, such as medical records, to assist in resolving the matter. Following receipt of all the necessary information, a thorough review is conducted and a determination made. When the outcome of the case affects the PCP, a representative will contact the PCP to apprise him/her of the determination.

If a member requests information on filing an inquiry, it should be forwarded to the respective customer service area: Blue Cross and Blue Shield of Kansas, Customer Service Center, 1133 SW Topeka Boulevard, Topeka, Kansas, 66629-1622. Phone: 785-232-4054 or 1-800-521-0117.

Policy Memo No. 7

Section I. Diagnostic Radiology Policy

Wording was added to paragraph A.3. to reflect current policy for multiple MRI and MRA services to allow the professional component (PC) for multiple tests at 100 percent rather than 50 percent for subsequent procedures.

I. DIAGNOSTIC RADIOLOGY POLICY

A. WHEN BOTH PROFESSIONAL AND TECHNICAL 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.

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.

Policy Memo No. 8

Section II. OB Services – Surgical Content of Service

Updated Paragraph C. to reflect current CPT coding.

II. OB SERVICES-SURGICAL CONTENT OF SERVICE

- 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).

Section I. Global Fee Concept

A definition of moderate (conscious) sedation was added to the policy memo under Components of a Global Surgical Package. A statement was also added showing local infiltration or topical application of anesthesia is also considered content of service.

I. GLOBAL FEE CONCEPT

A. COMPONENTS OF A GLOBAL SURGICAL PACKAGE

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.

Medically necessary moderate sedation when performed by a trained observer and directed by the surgeon will be allowed when performed in an office setting, except when the surgery procedure code is on CPT Appendix G or a corresponding HCPCS code. (Anesthesia for procedures on Appendix G and corresponding HCPCS codes is included in the MAP for the surgery and not separately payable.)

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. 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.

Section V. Dates of Service

This section was modified to clarify dates of service requirements.

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 postoperative 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.

Policy Memo No. 11

Section III. Additional Policy Clarification

In paragraph C, the reference to the Business Procedure Manual was changed to CPT book.

- C. BCBSKS recognizes modifiers and promotes their use for accurate claims payment. Please refer to your Current Procedural Terminology (CPT) book.

Policy Memo No. 12

This policy memo was revised adding definitions of general and regional anesthesia (I. DESCRIPTION), monitored anesthesia (VII. RELATED POLICIES, Paragraph D.), and moderate (conscious) sedation (VII. RELATED POLICIES, Paragraph E.). Additional formatting changes were made for improved clarity.

The entire policy memo is presented below:

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.
- 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. NERVE BLOCKS

Nerve blocks administered on the same day as an anesthesia service will be paid at 50 percent and the anesthesia service paid in full.

V. 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.

VI. 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 (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.

VII. 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 have 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 BLOCK 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.

C. OB ANESTHESIA

1. 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.

D. 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 (For example, 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.

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 patient 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 who is capable of initiating general anesthesia.

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 separate reimbursable service. BCBSKS will only reimburse one provider for an anesthesia procedure.



An Independent Licensee of the Blue Cross and Blue Shield Association.

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) or Premier Blue 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 or Premier Blue.

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



**Site of Service Differential Codes
Implemented January 1, 2006**

11042	11423	11623	19102	27096
11400	11440	11640	19103	28119
11401	11441	11641	20550	38221
11402	11442	11642	20551	62270
11403	11443	11643	20552	64450
11420	11620	11770	20553	64550
11421	11621	19100	20612	69433
11422	11622	19101	23350	

**Additional Site of Service Differential Codes
To Be Implemented January 1, 2007**

G0104	31615	43236	45330	46608	52005	57421	64402	64479
G0105	31620	43239	45331	46610	52007	57452	64405	64480
G0121	31622	44385	45332	46611	52010	57454	64408	64483
31231	31623	44386	45333	46612	52204	57455	64410	64484
31233	31624	44388	45335	46614	52214	57456	64412	64505
31235	31625	44389	45338	46615	52224	57460	64413	64508
31237	31628	44390	45339	50389	52265	57461	64415	64510
31238	31629	44391	45340	50551	52270	58353	64417	64517
31505	31632	44392	45378	50553	52275	58555	64418	64520
31510	31633	44393	45379	50555	52281	62280	64420	64530
31511	31635	44394	45380	50557	52283	62281	64421	92511
31512	31645	45300	45381	50561	52285	62282	64425	99170
31515	31646	45303	45382	50951	52310	62284	64430	
31525	31656	45305	45383	50953	52315	62290	64435	
31570	43200	45307	45384	50955	52327	62291	64445	
31575	43201	45308	45385	50957	52330	62310	64450	
31576	43202	45309	45386	50961	52332	62311	64470	
31577	43217	45315	46600	51715	56820	62318	64472	
31578	43234	45317	46604	52000	56821	62319	64475	
31579	43235	45320	46606	52001	57420	64400	64476	

NOTE: Reimbursement for any of the above codes billed during the first five months of 2006 is reflected on your charge comparison report.