

Blue Shield Guidelines

- Overview including
 - Contract Terms
 - Appeal Rights/Process
 - Medical Review
 - Content of Service Denials
 - Claims Filing
 - Refunds/Right to Offset
 - Charge Comparison Reports
 - Questions

CAP 2009 Contract Letter

- Mailed in July
- Approved by BCBSKS Board of Directors
- Includes updates for upcoming year

Contract Terms

- Provider agreement is perpetual; no action is necessary to retain contracting status
- Contract termination requires written notification 120 days prior to new calendar year

Policy Memo 1

Policies and Procedures

- **Medical Review Processes**
- Agree to accept review process decisions
- Must provide records upon request at no charge

Note: 2009 update-

Complete medical records are expected to contain all the elements required by Section X. below and by K.A.R. 100-24-1, as amended, which is hereby incorporated by reference and made a part of this policy.

The arbitration process is available only after all applicable review and/or appeal processes have been exhausted.

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.
- Note: 2009 update-** All requests for retrospective review, including corrected claims, 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.

The provider will be given a written response to the review as soon as possible, but no later than 60 days from receipt date. The RA may serve as the written response.

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.
- **NOTE:** Content of service issues are not considered eligible for claims appeals.

Denied Claims Appeals Procedure

cont...

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

Denied Claims Appeals Procedure

cont.....

- **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.

Denied Claims Appeals Procedure

cont.....

Note: 2009 update-

■ Second Level Appeal

Forward a written request to customer service with your letter addressed to the Chief Medical Officer. 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.

Denied Claims Appeals Procedure

cont.....

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.

Post-Payment Audits

Note: 2009 update-

Language was modified throughout to clarify both post-payment audits and post-payment audit appeals. The title vice president of medical affairs was changed to chief medical officer.

Utilization Review and Medical Necessity

- Medical necessity 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.

Utilization Review and Medical Necessity

- 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.

Appropriate Place of Service

- Agree to use contracting providers/facilities (to every extent possible).
- Actions taken for providers' lack of compliance will range from provider education to financial assessments and finally requesting contract cancellation.

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.

Examples of services considered Content of Service are:

- Examination of the patient

Content of Service

- Any entries into the patient's records
- Advice or information provided during or in association with the visit.
- Telephone calls and web based correspondence
- Content of Service denials are non waived and a provider write off.

Experimental or Investigational Procedures

- Any drug, device or medical treatment or procedure and related services that are Experimental or Investigational as defined by BCBSKS. Providers shall notify the patient when services to be rendered are considered E/I and may not be covered under the member's contract.

Non-Covered Services

- Non-covered denials are billable to the member
- Professional services rendered to an immediate family member are non-billable

Waiver Form

Situations requiring waivers

- Medical necessity denials
- Utilization denials
- Deluxe features/deluxe orthopedic or prosthetic appliances
- Patient demanded services
- Experimental/Investigational procedures

The waiver form must be:

1. Date of service and dollar amount specific.
2. Retained in patient's file at provider's place of business. (Use GA modifier).
3. Presented on an individual basis to patient. It may not be a blanket statement.
4. Acknowledged by patient that he/she will be responsible for the amount of the charge.
5. Patient and service specific.
6. Signed prior to receipt of service.



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

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;
- Document the medical need for the services;
- Agrees to make available all information necessary to carry out these terms at no charge to BCBSKS within 30 days of the request.

Documentation

Note: 2009 update-In the case of typed or electronic medical records, the entry must be authenticated (signed) by the provider at the time of submission.

- 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.

Note: 2009 update- 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.

Documentation

- The members contract gives us the ability to obtain this information without a signed patient release.

Documentation Guides for Medical Services

- Sufficiently document services performed.
- Could be the difference between covered/non.
- What documentation would you need to see if you were the reviewer and you need to justify your treatment?

Documentation-Minimal Requirements

Records must be:

- Legible in both readability and content,
- Contain only those terms and abbreviations easily comprehended by similar licensees/peers.
- Contain identification of the patient on every page.
- Indicate the dates any professional service was provided. List start/stop times on all timed CPT codes or total time.

Documentation-Minimal Requirements

- Contain pertinent and significant information concerning the patient's presenting condition.
- Reflect what examination or treatment was performed and physical area treated, vital signs obtained and test (lab, x-ray, etc.), performed and the findings of each.
- Indicate the initial diagnosis and the patient's initial reason for seeking provider care.
- When records are requested, all notes should be signed and dated by the scribing clinician, including typed electronic medical records.

Claims Filing

- Submit in designated CMS-1500 format
- Include NPI information
- Usual charge
- Look to BCBSKS for payment except; deductibles, co-insurance, indemnified payment balances, non-covered amounts
- Submit within 15 months of service date or hospital discharge date
- Credits returned within 30 days to member

Claims Filing

Note: 2009 update-

Language was added explaining add-on codes as defined by CPT, must never be reported as stand-alone procedures. Language was also added to reinforce that BCBSKS has the discretion to determine the applicability of codes/modifiers.

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.

Right of Offset

- BCBSKS will, through auto deduction processes, exercise the right of offset for claims previously paid. To accomplish this, BCBSKS will supply the providers detailed individual claims information on the remittance advice so amounts can be reconciled efficiently.

Reimbursement And Policy Changes

- 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.

Application of Contract

- Policies apply to service benefit programs, indemnity programs and to self-insured plans administered by BCBSKS.
- When BCBSKS is secondary and primary allowance is less per contract; primary amount is considered full allowance.
- Allows other entities to purchase access to our network.

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 1 – May 31 each year.

Questions??

Thank you for your participation.