

## POLICIES AND PROCEDURES FOR 2010

On July 24, 2009, the 2010 Hospital Policies and Procedures were sent to hospital chief executors explaining the updates and changes for 2010. At that same time, the 2010 MAPS were also included in that mailing. Please attempt to obtain a copy of this communication to prepare for any differences in policy or reimbursement that you might see in 2010. We are not going to go through all the changes but merely the issues that would be of concern.

### MEDICAL POLICIES

<p>Page 19, <u>Section III. Medical and Utilization Review</u>, Medical Policies</p>	<p>This section reflects the Blue Cross and Blue Shield of Kansas Board expectation that BCBSKS staff will establish and amend medical policy that does not originate in Liaison Committee with report of those policies to the Board. Added the following paragraphs.</p> <p><i>"The BCBSKS Board of Directors authorized the following resolution regarding establishing and amending medical policy changes and staff's authority.</i></p> <p><i>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</i></p> <p><i>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,</i></p> <p><i>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 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</i></p> <p><i>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."</i></p>
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## APPEALS

Page 25, <u>Section V. Appeals, Provider Appeals For Experimental/Investigational or Not Medically Necessary Services</u>	Extended the Contracting Provider's timeframe for this type of appeal from 120 to 180 days.
Page 26 & 27, <u>Section V. Appeals, MS-DRG Assignment</u>	Further clarified that Initial Appeals are reviewed by the <i>Reimbursement Staff Review Committee</i> and Final Appeals are reviewed by the <i>Vice President of Provider Relations and Medical Affairs</i> .

## ACUTE HOSPITAL PAYMENT ATTACHMENT

PAGE and SECTION	DESCRIPTION
	Removed all references to " <i>Premier Blue</i> " and " <i>Blue Select</i> " as those products are no longer offered by BCBSKS.
Page 2 & 3, Inpatient Reimbursement	<p>Added the following language regarding "Hospital Acquired Conditions" to include any future CMS adopted Hospital Acquired Conditions.</p> <p><i>"The BCBS list of 'Hospital Acquired Conditions' shall automatically include all future adopted CMS conditions. The update shall be immediate upon adoption even if additions occur mid-year. The CMS additions do not constitute a change in policy."</i></p>
Page 6, Skilled Nursing Unit And Swing-Bed Claims	<p>Removed Premier Blue language as that product is no longer offered by BCBSKS. <b>Removed the following paragraphs.</b></p> <p><i>"Premier Blue – A skilled nursing unit or swing-bed that holds a Premier Blue contracting agreement will be reimbursed at the lesser of charge or the contracted Premier Blue per diem rate when providing services to a Premier Blue member who has obtained a referral for skilled care from their primary care physician.</i></p> <p><i>When Premier Blue members do not obtain a referral from their primary care physician, if the services are deemed medically necessary and self-referral benefits are available, the provider will be reimbursed at the lesser of charge or CAP MAP based on the MS-DRG assigned to the inpatient skilled stay."</i></p>



<p>Page 9 &amp; 10, Preventable Adverse Events</p>	<p>Added the following paragraph relating to CMS "Never Events" to include any future CMS adopted Never Events.</p> <p><i>"The Blue Cross and Blue Shield list of "Preventable Adverse Events" shall automatically include all future CMS adopted "Never Events". The update shall be immediate upon adoption even if the addition occurs mid year. The CMS additions do not constitute a policy change and neither the patient nor BCBS shall pay for the medical errors."</i></p>
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## STATE OF KANSAS UPDATE

The State of Kansas has specific appeal procedures that must be followed. Please note that the actual timely filing periods are the same for Blue Cross and Blue Shield insureds; however, the time period to file an appeal is 180 days (six months) for the State of Kansas vs 15 months for Blue Cross and Blue Shield.

At times, Blue Cross and Blue Shield finds it necessary to request information or clarification to accurately adjudicate claims. When BCBSKS makes such requests, the Contracting Provider should submit the requested information as soon as possible but information must be received no later than 15 months of the date of service or discharge from the inpatient admission. This coincides with the timely filing limitations for services.

### **CLAIMS AND APPEAL PROCEDURES (from the State of Kansas Policy Information)**

This section outlines the procedures and time frames applicable to Claims decisions and Appeal decisions for Urgent Care Claims, Pre-Service Claims, and Post-Service Claims.

It is the policy of the Third Party Administrator (TPA) to provide Covered Members a full and fair review of Claims and Appeal decisions. INITIAL Claim Decisions will be made no later than the time frames set forth below:



Action	Urgent Care Claim	Pre-Service Claim	Post Service Claim
<b>Initial Benefit Decision</b> (from the date the Claim is received by the TPA)	72 hours	15 days	30 days
Extension (from the date the Claim is received by the TPA)	None-If additional information is needed to make a decision, the TPA must notify the Covered Person within 24 hours after receipt of the Claim. A decision must be made within 48 hours of the earlier of: (i) receipt of the information; or (ii) expiration of the time period allowed for the Covered Person to provide the information. *	30 days*	45 days*
Time for Covered Person to provide more information (from the date the information was requested by the TPA)	No less than 48 hours	No less than 45 days	No less than 45 days

\* A Covered Member may voluntarily agree to provide the TPA additional time within which to make a decision.

### Process for Submitting an Appeal

A Covered Member or the Covered Member's Authorized Representative has the right to obtain, without charge, copies of the documents relating to the Adverse Benefit Decision and may Appeal an Adverse Benefit Decision from an initial Claims decision by:

Submitting the Appeal in writing to Blue Cross and Blue Shield of Kansas, Inc.  
1133 SW Topeka Blvd, Topeka, Kansas 66629

Or

Sending a fax to 785 290 0711 Or Sending an email to [csc@bcbsks.com](mailto:csc@bcbsks.com)



If the Covered Member believes his or her health would be seriously harmed by waiting for a decision under the standard timeframes set forth below, he or she may make an oral request for an Expedited Appeal by calling Member Services at 1-800-332-0307.

Expedited Appeals are not subject to a second level of appeals.

Appeals should include:

- The Covered Member's name and ID number.
- Specific information relating to a reason for the Appeal.
- The Covered Member's expectation for resolution.
- Copies of medical records or other documentation that the Covered Member wishes to be considered in the Appeal.

All levels of the appeals process will be handled by individuals not involved in a previous determination. Appeals involving clinical issues will be reviewed by a practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment in question. If time permits, the Covered Member may be referred for a second opinion.

### Appeal of Initial Adverse Decisions (First Level Appeal)

A decision on the first level Appeal will be made as quickly as the situation demands but in no event later than the time frames set forth below:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
<b>Time to File Appeal (from the date the TPA made the initial Adverse Benefit Decision)</b>	180 days	180 days	180 days
Initial Appeal Decision (from the date the Appeal is received by the TPA)	72 hours	15 days	30 days
Extension (from the date the Appeal is received by the TPA)	None*	None*	None*

\* A Covered Member may voluntarily agree to provide the TPA additional time within which to make a decision.



## Appeal of a First Level Appeal Adverse Decisions (Second Level Appeal)

If the Covered Member is not satisfied with the outcome of the First Level Appeal on a **Pre-Service or Post-Service Claim**, he or she has the right to initiate a final appeal in the manner described in the process for Submitting an Appeal section, above. The Covered Member may attend the Second Level Appeals Committee meeting to present their case or communicate via a conference call. A decision on the second level Appeal will be made as quickly as the situation demands but in no event later than the time frames set forth below:

Action	Pre-Service Claim	Post-Service Claim
Time to File Appeal (from the date the TPA made the first level Appeal Decisions)	180 days	180 days
Appeal Decision (from the date the Appeal is received by the TPA)	15 days	30 days
Extension (from the date the Appeal is received by the TPA)	None*	None*

\* A Covered Member may voluntarily agree to provide the TPA additional time within which to make a decision.

## Second Level Appeal Relating To An Adverse Decision That is An Adverse Decision Eligible for External Review

- A. Waiver of second level Appeal. If a Member wished to waive their right to a second level Appeal and proceed to the External Review, they may do so by sending written notice to the TPA. This waiver will serve to exhaust all of the available internal appeals or review procedures for the Claim being reviewed.
- B. Second level Appeal. If a Member chooses not to waive their right to a second level Appeal, the Member will have the right to appear in person before a designated representative or representatives of the TPA. At least one of those designated representatives who will be deciding the second level Appeal shall be a physician and shall be present in person, by telephone or by other electronic means, The Member has a right to:
  1. Received from the TPA, upon request, copies of all documents, records and other information that are not confidential or privileged relevant to the Insured's request for benefits;



2. Have a reasonable and adequate amount of time to present the Member's case to a designated representative or representatives of the TPA who will be deciding the second level Appeal;
3. Submit written comments, documents, records and other material relating to the request for benefits for the second level Appeal for the TPA to consider when conducting the second level Appeal both before and, if applicable, at the second level Appeal meeting;
4. Prior to or during the second level Appeal ask questions relevant to the subject matter of any representative of the TPA that is participating in the second level Appeal provided that such representative may respond verbally if the question is asked in person during a Member's appearance in conjunction with the second level Appeal or in writing, if the questions are asked in writing, not more than 30 days from receipt of such written questions;
5. Be assisted or represented at the second level Appeal meeting by an individual or individuals of the Insured's choice; and
6. Record the proceedings of the second level Appeal meeting at the expense of the Insured.

C. A Member, or the Member's Authorized Representative, wishing to request to appear in person in conjunction with the second level Appeal, shall make the request to the TPA within five working days before the date of the scheduled second level Appeal meeting except that in the case of an emergency medical condition, such request must be made no less than 24 hours prior to the scheduled second level Appeal meeting.

**D. The TPA shall provide the Member a written decision setting forth the relevant facts and conclusions supporting its decision within:**

- 1. Seventy-two hours if the second level Appeal involves an Urgent Care Claim**
- 2. Fifteen business days if the second level Appeal involves a Pre-Service Claim, and**
- 3. Thirty days if the second level Appeal involves a Post-Service Claim.**

## **Procedure For Pursuing An External Review**

The Covered Member has the right to request an External Review after a final Adverse Benefit Decision has been rendered, or when the Covered Member has not received a final Adverse Benefit Decision within 60 days of seeking such review, unless the delay was requested by the Covered Member for eligible claims as defined in the Claims Eligible for External Review definition. The TPA will notify the Covered Member in writing regarding a final Adverse Benefit Decision and of the opportunity to request an External Review.

Within 90 days of receipt of the final Adverse Benefit decision, the Covered Member, the treating Physician or Health Care Provider acting on behalf of the Covered Member with written authorization from the Covered Member, or a legally authorized designee of the Covered Member **must make a written request for an External Review to the State Employee Health Plan, 900 SW Jackson Rm 900 N, Topeka, Kansas 66612.** State Employee Health Plan will work with the Kansas Insurance Department to obtain an external review.

Within 10 business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Department will notify the Covered Member and other involved parties as to whether the request for External Review is granted.



For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Covered Member and the Kansas Insurance Department within 30 days. The External Review Organization will issue its written decision within 7 business days when the request for External Review involves an Emergency Medical Condition. If any party is not satisfied with the decision of the External Review organization, they may pursue normal remedies of law.

The right to External Review shall not be construed to change the terms of coverage under this Benefit Description. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts. A Covered Member may not pursue, either concurrently or sequentially, an External Review under both state and federal law. The Covered Member shall have the option of designating which External Review process will be utilized.

## **Right To A Judicial Review**

After you have pursued the first and second level review of an Adverse Benefit Decision, you have the right to sue in federal or state court, even if you do not request External Review. In all events, such suit or proceedings must be commenced no later than five (5) years after the date from the time written proof of loss is requested to be given.

## **CLAIM ADJUSTMENTS**

*Beginning January 1, 2009, the State of Kansas group modified their requirements **for claim adjustments**.* The new requirement states that *once a claim has been adjudicated, any further processing would need to be initiated within 180 days (6 months) of adjudication.* Although your provider agreement with Blue Cross and Blue Shield of Kansas (BCBSKS) typically allows providers to initiate claim adjustments within 15 months, the time restriction imposed by the State of Kansas for their employee group takes precedence.

Most State of Kansas memberships can be identified by the alpha prefix KSE or the group number on their identification cards. Full State of Kansas benefit descriptions can be found on the BCBSKS Web site at: <http://www.bcbsks.com/Customerservice/Members/State/index.htm>.



## GENERAL REIMBURSEMENT CHANGES

1. The inpatient maximum allowable payments (MAPs) will receive an overall increase.
2. For acute care hospitals with Medicare-certified rehabilitation units **that share the same NPI as the acute care hospital**, when the rehabilitation stay follows an acute stay, a daily allowance INCREASE will apply for each day that a patient resides in that rehabilitation unit. Blue Choice will be 95 percent of the CAP MAP.
3. For acute care hospitals with Medicare-certified rehabilitation units **that have separate NPIs**, separate claims are submitted for the inpatient rehab charges. The rehab claim will be paid at an INCREASED inpatient per diem.
4. For acute-care hospitals with Medicare certified psychiatric units **that have separate NPIs**, the inpatient per diem will increase. Blue Choice will be 95 percent of the CAP MAP.
5. Most outpatient surgical MAPs will increase.
6. Outpatient MAPs for physical, speech and occupational therapy and most other therapeutic services will increase.
7. Technical component for some specialized imaging:
  - o The MAPs for mobile PET scan units will remain the same in 2010 as in 2009. The MAPs for PET scan units where a local oncologist is on-site (formerly referred to as fixed PET scan units) will increase.
  - o The MAP for the technical component for CT scans will increase.
  - o The MAPs for the technical component for MRI and MRA will increase.
8. Laboratory MAPs will remain the same in 2010 as in 2009.
9. The MAP for sleep studies will remain the same in 2010 as in 2009.
10. Most outpatient pharmacy charges will continue to be reimbursed utilizing a formula based on average sales price (ASP) or average wholesale price (AWP). Drugs and administration for infusion and pharmaceutical therapy that are subject to MAPs appear on the listing enclosed.
11. The MAPs for covered home health services will increase.
12. The BCBSKS home hospice maximum allowable payments will continue to be the same as the Medicare routine home care payment rate. Therefore, if your Medicare rate has changed since last year, please forward that information to us. Hospice agencies whose inpatient programs have been reviewed and approved by BCBSKS may receive additional reimbursement for inpatient hospice services. With prior approval, inpatient hospice services will be paid at the lesser of charge or a percentage of the Medicare inpatient hospice rate. Without prior approval, BCBSKS will reimburse inpatient hospice services at the home hospice rate.



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## PROCEDURES IN THE EMERGENCY ROOM

If a patient is seen in the Emergency Room and a procedure is performed, such as a suture repair, a splinting, removal of a foreign body, both the code for the E&M visit and the procedure done should be billed with a charge.

In the example following, the patient came to the ER and had a repair of a wound and a tetanus shot. There was a charge for the initial ER assessment and although the code for the procedure was noted, there was no charge made. In this instance, BCBSKS will not apply a MAP payment to this claim since it was due to an accident so reimbursement would be made at charges less discount plus any additional amount for the add-on codes on this claim. If the hospital would have charged for the procedure, reimbursement would have been greater. It is unlikely that the charge for the E&M visit (\$192.00) included the charge for the procedure.

CPT code 90715 was also used to indicate an intramuscular tetanus injection was given with a charge of \$207.00. It is recommended revenue code 0636 be used when there is a CPT/HCPC code available. It is possible that within the \$207.00 charge there are other drugs included, but if that is the case, those drugs should be billed on a separate line using the appropriate codes. The code for the administration of a tetanus vaccine is 90471 rather than 96372. The administration codes on the Charge Master may have the same charges but correct codes should be used at all times.

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / H/PPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON COVERED CHARGES
0250	DRUGS	90715	070309	1	207.00	
0270	MED/SURG SUP		070309	5	95.00	
0450	ER	12032	070309	1		
0450	ER	99282	070309	1	192.00	
0450	ER	96372	070309	1	65.00	



## MULTIPLE PROCEDURES

Another situation that should be considered is multiple procedures being done in the treatment area or possibly in the OR. If it is the hospital's practice to submit both procedures but the charge would be shown only on one line, make sure that the procedure WITHOUT the charge is not a CPT code that has an add-on MAP. ***If there is not a charge for a procedure that has an add-on MAP, you will not be paid for that service.*** Refer to the MAP listing and make sure that all services with add-on MAPs are included in the hospital CDM with charges associated with that code.

BCBSKS will provide reimbursement on only one procedure (unless the other procedure has an add-on MAP) when multiple procedures are performed. The system will look for the procedure that has a MAP and will pay at that rate...even if that MAP is assigned to the lesser service. If the primary procedure provided does not have a MAP assigned but the lesser service does have a MAP, the system will pay accordingly. When hospital staff reviews reimbursement and this is found to be the case, contact your provider representative and send a copy of the operative report along with the remittance advice and a copy of the claim for individual consideration.

Following is the list of Add-On codes for additional Blue Cross reimbursement. It is imperative that you have these codes loaded with a charge in the CDM if you provide such services.

<u>CD</u>	<u>DS</u>	<u>ADDON</u>
11000	DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; UP TO 10% OF	X
11010	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL ASSOCIATED WITH	X
11011	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL ASSOCIATED WITH	X
11012	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL ASSOCIATED WITH	X
11040	DEBRIDEMENT; SKIN, PARTIAL THICKNESS	X
11041	DEBRIDEMENT; SKIN, FULL THICKNESS	X
11042	DEBRIDEMENT; SKIN, AND SUBCUTANEOUS TISSUE	X
11043	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISSUE, AND MUSCLE	X
11044	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISSUE, MUSCLE, AND BONE	X
16020	DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS, INITIAL OR	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
16025	DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS, INITIAL OR	X
16030	DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS, INITIAL OR	X
19030	INJECTION PROCEDURE ONLY FOR MAMMARY DUCTOGRAM OR GALACTOGRAM	X
19290	PREOPERATIVE PLACEMENT OF NEEDLE LOCALIZATION WIRE, BREAST;	X
19295	IMAGE GUIDED PLACEMENT, METALLIC LOCALIZATION CLIP, PERCUTANEOUS,	X
20500	INJECTION OF SINUS TRACT; THERAPEUTIC (SEPARATE PROCEDURE)	X
20501	INJECTION OF SINUS TRACT; DIAGNOSTIC (SINOGRAM)	X
20550	INJECTION(S); SINGLE TENDON SHEATH, OR LIGAMENT, APONEUROSIS (EG,	X
20551	INJECTION(S); SINGLE TENDON ORIGIN/INSERTION	X
20552	INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), ONE OR TWO	X
20553	INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), THREE OR MORE	X
23350	INJECTION PROCEDURE FOR SHOULDER ARTHROGRAPHY OR ENHANCED CT/MRI	X
24220	INJECTION PROCEDURE FOR ELBOW ARTHROGRAPHY	X
25246	INJECTION PROCEDURE FOR WRIST ARTHROGRAPHY	X
27093	INJECTION PROCEDURE FOR HIP ARTHROGRAPHY; WITHOUT ANESTHESIA	X
27095	INJECTION PROCEDURE FOR HIP ARTHROGRAPHY; WITH ANESTHESIA	X
27096	INJECTION PROCEDURE FOR SACROILIAC JOINT, ARTHROGRAPHY AND/OR	X
27370	INJECTION PROCEDURE FOR KNEE ARTHROGRAPHY	X
27648	INJECTION PROCEDURE FOR ANKLE ARTHROGRAPHY	X
29065	APPLICATION; SHOULDER TO HAND (LONG ARM)	X
29075	APPLICATION; ELBOW TO FINGER (SHORT ARM)	X
29085	APPLICATION; HAND AND LOWER FOREARM (GAUNTLET)	X
29086	APPLICATION, CAST; FINGER (EG, CONTRACTURE)	X
29105	APPLICATION OF LONG ARM SPLINT (SHOULDER TO HAND)	X
29125	APPLICATION OF SHORT ARM SPLINT (FOREARM TO HAND); STATIC	X
29126	APPLICATION OF SHORT ARM SPLINT (FOREARM TO HAND); DYNAMIC	X
29130	APPLICATION OF FINGER SPLINT; STATIC	X
29131	APPLICATION OF FINGER SPLINT; DYNAMIC	X
29240	STRAPPING; SHOULDER (EG, VELPEAU)	X
29260	STRAPPING; ELBOW OR WRIST	X
29280	STRAPPING; HAND OR FINGER	X
29345	APPLICATION OF LONG LEG CAST (THIGH TO TOES);	X
29355	APPLICATION OF LONG LEG CAST (THIGH TO TOES); WALKER OR AMBULATORY	X
29358	APPLICATION OF LONG LEG CAST BRACE	X
29365	APPLICATION OF CYLINDER CAST (THIGH TO ANKLE)	X
29405	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES);	X
29425	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES); WALKING OR	X
29440	ADDING WALKER TO PREVIOUSLY APPLIED CAST	X
29445	APPLICATION OF RIGID TOTAL CONTACT LEG CAST	X
29450	APPLICATION OF CLUBFOOT CAST WITH MOLDING OR MANIPULATION, LONG OR	X
29505	APPLICATION OF LONG LEG SPLINT (THIGH TO ANKLE OR TOES)	X
29515	APPLICATION OF SHORT LEG SPLINT (CALF TO FOOT)	X
29520	STRAPPING; HIP	X
29530	STRAPPING; KNEE	X
29540	STRAPPING; ANKLE AND/OR FOOT	X
29550	STRAPPING; TOES	X
29580	STRAPPING; UNNA BOOT	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
29590	DENIS-BROWNE SPLINT STRAPPING	X
29700	REMOVAL OR BIVALVING; GAUNTLET, BOOT OR BODY CAST	X
29705	REMOVAL OR BIVALVING; FULL ARM OR FULL LEG CAST	X
29710	REMOVAL OR BIVALVING; SHOULDER OR HIP SPICA, MINERVA, OR RISSER	X
29715	REMOVAL OR BIVALVING; TURNBUCKLE JACKET	X
30200	INJECTION INTO TURBINATE(S), THERAPEUTIC	X
32405	BIOPSY, LUNG OR MEDIASTINUM, PERCUTANEOUS NEEDLE	X
32421	THORACENTESIS, PUNCTURE OF PLEURAL CAVITY FOR ASPIRATION,	X
32422	THORACENTESIS WITH INSERTION OF TUBE, INCLUDES WATER SEAL (EG,	X
36000	INTRODUCTION OF NEEDLE OR INTRACATHETER, VEIN	X
36002	INJECTION PROCEDURES (EG, THROMBIN) FOR PERCUTANEOUS TREATMENT OF	X
36005	INJECTION PROCEDURE FOR EXTREMITY VENOGRAPHY (INCLUDING INTRODUCTION	X
36010	INTRODUCTION OF CATHETER, SUPERIOR OR INFERIOR VENA CAVA	X
36011	SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; FIRST ORDER BRANCH (EG,	X
36012	SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; SECOND ORDER, OR MORE	X
36013	INTRODUCTION OF CATHETER, RIGHT HEART OR MAIN PULMONARY ARTERY	X
36100	INTRODUCTION OF NEEDLE OR INTRACATHETER, CAROTID OR VERTEBRAL ARTERY	X
36120	INTRODUCTION OF NEEDLE OR INTRACATHETER; RETROGRADE BRACHIAL ARTERY	X
36140	INTRODUCTION OF NEEDLE OR INTRACATHETER; EXTREMITY ARTERY	X
36145	INTRODUCTION OF NEEDLE OR INTRACATHETER; ARTERIOVENOUS SHUNT CREATED	X
36160	INTRODUCTION OF NEEDLE OR INTRACATHETER, AORTIC, TRANSLUMBAR	X
36200	INTRODUCTION OF CATHETER, AORTA	X
36215	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER	X
36216	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER	X
36217	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR	X
36245	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER	X
36246	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER	X
36247	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR	X
36410	VENIPUNCTURE, AGE 3 YEARS OR OLDER, NECESSITATING PHYSICIAN'S SKILL	X
36591	COLLECTION OF BLOOD SPECIMEN FROM A COMPLETELY IMPLANTABLE	X
36600	ARTERIAL PUNCTURE, WITHDRAWAL OF BLOOD FOR DIAGNOSIS	X
51600	INJECTION PROCEDURE FOR CYSTOGRAPHY OR VOIDING URETHROCYSTOGRAPHY	X
51605	INJECTION PROCEDURE AND PLACEMENT OF CHAIN FOR CONTRAST AND/ OR CHAIN	X
51610	INJECTION PROCEDURE FOR RETROGRADE URETHROCYSTOGRAPHY	X
51700	BLADDER IRRIGATION, SIMPLE, LAVAGE AND/OR INSTILLATION	X
51701	INSERTION OF NON-INDWELLING BLADDER CATHETER (EG, STRAIGHT	X
51702	INSERTION OF TEMPORARY INDWELLING BLADDER CATHETER; SIMPLE (EG,	X
51703	INSERTION OF TEMPORARY INDWELLING BLADDER CATHETER; COMPLICATED (EG,	X
51798	MEASUREMENT OF POST-VOIDING RESIDUAL URINE AND/OR BLADDER CAPACITY BY	X
58340	CATHETERIZATION AND INTRODUCTION OF SALINE OR CONTRAST MATERIAL FOR	X
59000	AMNIOCENTESIS; DIAGNOSTIC	X
59020	FETAL CONTRACTION STRESS TEST	X
59025	FETAL NON-STRESS TEST	X
59030	FETAL SCALP BLOOD SAMPLING	X
59050	FETAL MONITORING DURING LABOR BY CONSULTING PHYSICIAN (IE,	X
59051	FETAL MONITORING DURING LABOR BY CONSULTING PHYSICIAN (IE,	X
62270	SPINAL PUNCTURE, LUMBAR, DIAGNOSTIC	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
62272	SPINAL PUNCTURE, THERAPEUTIC, FOR DRAINAGE OF CEREBROSPINAL FLUID (BY	X
62280	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED	X
62281	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED	X
62282	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED	X
62284	INJECTION PROCEDURE FOR MYELOGRAPHY AND/OR COMPUTED TOMOGRAPHY,	X
62310	INJECTION, SINGLE (NOT VIA INDWELLING CATHETER), NOT INCLUDING	X
62311	INJECTION, SINGLE (NOT VIA INDWELLING CATHETER), NOT INCLUDING	X
62318	INJECTION, INCLUDING CATHETER PLACEMENT, CONTINUOUS INFUSION OR	X
62319	INJECTION, INCLUDING CATHETER PLACEMENT, CONTINUOUS INFUSION OR	X
70010	MYELOGRAPHY, POSTERIOR FOSSA, RADIOLOGICAL SUPERVISION AND	X
70336	MAGNETIC RESONANCE (EG, PROTON) IMAGING, TEMPOROMANDIBULAR JOINT(S)	X
70450	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL	X
70460	COMPUTERIZED AXIAL TOMOGRAPHY, HEAD OR BRAIN; WITH CONTRAST	X
70470	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL,	X
70480	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER,	X
70481	COMPUTERIZED AXIAL TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR	X
70482	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER,	X
70486	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL	X
70487	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITH CONTRAST MATERIAL(S)	X
70488	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL,	X
70490	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL	X
70491	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITH CONTRAST MATERIAL(S)	X
70492	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL	X
70540	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND/OR NECK;	X
70542	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND NECK; WITH	X
70543	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND NECK;	X
70544	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITHOUT CONTRAST MATERIAL(S)	X
70545	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITH CONTRAST MATERIAL(S)	X
70546	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITHOUT CONTRAST MATERIAL(S),	X
70547	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITHOUT CONTRAST MATERIAL(S)	X
70548	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITH CONTRAST MATERIAL(S)	X
70549	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITHOUT CONTRAST MATERIAL(S)	X
70551	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN	X
70552	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN	X
70553	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN	X
70554	MAGNETIC RESONANCE IMAGING, BRAIN, FUNCTIONAL MRI; INCLUDING TEST	X
70555	MAGNETIC RESONANCE IMAGING, BRAIN, FUNCTIONAL MRI; REQUIRING	X
70557	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM	X
70558	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM	X
70559	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM	X
71250	COMPUTED TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL	X
71260	COMPUTERIZED AXIAL TOMOGRAPHY, THORAX; WITH CONTRAST MATERIAL(S)	X
71270	COMPUTED TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL, FOLLOWED BY	X
71550	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR EVALUATION OF	X
71551	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR EVALUATION OF	X
71552	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR EVALUATION OF	X
71555	MAGNETIC RESONANCE ANGIOGRAPHY, CHEST (EXCLUDING MYOCARDIUM), WITH	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
72125	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL	X
72126	COMPUTERIZED AXIAL TOMOGRAPHY, CERVICAL SPINE; WITH CONTRAST MATERIAL	X
72127	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL,	X
72128	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST MATERIAL	X
72129	COMPUTERIZED AXIAL TOMOGRAPHY, THORACIC SPINE; WITH CONTRAST MATERIAL	X
72130	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST MATERIAL,	X
72131	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL	X
72132	COMPUTERIZED AXIAL TOMOGRAPHY, LUMBAR SPINE; WITH CONTRAST MATERIAL	X
72133	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL,	X
72141	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS,	X
72142	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS,	X
72146	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS,	X
72147	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS,	X
72148	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS,	X
72149	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS,	X
72156	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS,	X
72157	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS,	X
72158	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS,	X
72159	MAGNETIC RESONANCE ANGIOGRAPHY, SPINAL CANAL AND CONTENTS, WITH OR	X
72192	COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL	X
72193	COMPUTERIZED AXIAL TOMOGRAPHY, PELVIS; WITH CONTRAST MATERIAL(S)	X
72194	COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL, FOLLOWED BY	X
72195	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS; WITHOUT CONTRAST	X
72196	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS; WITH CONTRAST	X
72197	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS; WITHOUT CONTRAST	X
72198	MAGNETIC RESONANCE ANGIOGRAPHY, PELVIS, WITH OR WITHOUT CONTRAST	X
72240	MYELOGRAPHY, CERVICAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	X
72255	MYELOGRAPHY, THORACIC, RADIOLOGICAL SUPERVISION AND INTERPRETATION	X
72265	MYELOGRAPHY, LUMBOSACRAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	X
72270	MYELOGRAPHY, TWO OR MORE REGIONS (EG, LUMBAR/THORACIC,	X
73200	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL	X
73201	COMPUTERIZED AXIAL TOMOGRAPHY, UPPER EXTREMITY; WITH CONTRAST	X
73202	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL,	X
73218	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN	X
73219	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN	X
73220	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN	X
73221	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER	X
73222	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER	X
73223	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER	X
73225	MAGNETIC RESONANCE ANGIOGRAPHY, UPPER EXTREMITY, WITH OR WITHOUT	X
73700	COMPUTED TOMOGRAPHY, LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL	X
73701	COMPUTERIZED AXIAL TOMOGRAPHY, LOWER EXTREMITY; WITH CONTRAST	X
73702	COMPUTED TOMOGRAPHY, LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL,	X
73718	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY OTHER THAN	X
73719	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY OTHER THAN	X
73720	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY OTHER THAN	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
73721	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER	X
73722	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER	X
73723	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER	X
73725	MAGNETIC RESONANCE ANGIOGRAPHY, LOWER EXTREMITY, WITH OR WITHOUT	X
74150	COMPUTED TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL	X
74160	COMPUTERIZED AXIAL TOMOGRAPHY, ABDOMEN; WITH CONTRAST MATERIAL(S)	X
74170	COMPUTED TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST	X
74181	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN; WITHOUT CONTRAST	X
74182	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN; WITH CONTRAST	X
74183	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN; WITHOUT CONTRAST	X
74185	MAGNETIC RESONANCE ANGIOGRAPHY, ABDOMEN, WITH OR WITHOUT CONTRAST	X
75557	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION	X
75558	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION	X
75559	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION	X
75560	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION	X
75561	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND	X
75562	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND	X
75563	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND	X
75564	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND	X
75650	ANGIOGRAPHY, CERVICOCEREBRAL, CATHETER, INCLUDING VESSEL ORIGIN,	X
75658	ANGIOGRAPHY, BRACHIAL, RETROGRADE, RADIOLOGICAL SUPERVISION AND	X
75660	ANGIOGRAPHY, EXTERNAL CAROTID, UNILATERAL, SELECTIVE, RADIOLOGICAL	X
75662	ANGIOGRAPHY, EXTERNAL CAROTID, BILATERAL, SELECTIVE, RADIOLOGICAL	X
75665	ANGIOGRAPHY, CAROTID, CEREBRAL, UNILATERAL, RADIOLOGICAL SUPERVISION	X
75671	ANGIOGRAPHY, CAROTID, CEREBRAL, BILATERAL, RADIOLOGICAL SUPERVISION	X
75676	ANGIOGRAPHY, CAROTID, CERVICAL, UNILATERAL, RADIOLOGICAL SUPERVISION	X
75680	ANGIOGRAPHY, CAROTID, CERVICAL, BILATERAL, RADIOLOGICAL SUPERVISION	X
75685	ANGIOGRAPHY, VERTEBRAL, CERVICAL, AND/OR INTRACRANIAL, RADIOLOGICAL	X
75945	INTRAVASCULAR ULTRASOUND (NON-CORONARY VESSEL), RADIOLOGICAL	X
75946	INTRAVASCULAR ULTRASOUND (NON-CORONARY VESSEL), RADIOLOGICAL	X
76150	XERORADIOGRAPHY	X
76380	COMPUTED TOMOGRAPHY, LIMITED OR LOCALIZED FOLLOW-UP STUDY	X
76390	MAGNETIC RESONANCE SPECTROSCOPY	X
76497	UNLISTED COMPUTED TOMOGRAPHY PROCEDURE (EG, DIAGNOSTIC,	X
76498	UNLISTED MAGNETIC RESONANCE PROCEDURE (EG, DIAGNOSTIC,	X
76499	UNLISTED DIAGNOSTIC RADIOGRAPHIC PROCEDURE	X
76506	ECHOENCEPHALOGRAPHY, REAL TIME WITH IMAGE DOCUMENTATION (GRAY SCALE)	X
76511	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; QUANTITATIVE A-SCAN ONLY	X
76512	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; B-SCAN (WITH OR WITHOUT	X
76513	OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; ANTERIOR SEGMENT	X
76514	OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; CORNEAL PACHYMETRY,	X
76516	OPHTHALMIC BIOMETRY BY ULTRASOUND ECHOGRAPHY, A-SCAN;	X
76519	OPHTHALMIC BIOMETRY BY ULTRASOUND ECHOGRAPHY, A-SCAN; WITH	X
76529	OPHTHALMIC ULTRASONIC FOREIGN BODY LOCALIZATION	X
76536	ULTRASOUND, SOFT TISSUES OF HEAD AND NECK (EG, THYROID, PARATHYROID,	X
76604	ULTRASOUND, CHEST (INCLUDES MEDIASTINUM), REAL TIME WITH IMAGE	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
76645	ULTRASOUND, BREAST(S) (UNILATERAL OR BILATERAL), REAL TIME WITH IMAGE	X
76700	ULTRASOUND, ABDOMINAL, REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	X
76705	ULTRASOUND, ABDOMINAL, B-SCAN AND/OR REAL TIME WITH IMAGE	X
76770	ULTRASOUND, RETROPERITONEAL (EG, RENAL, AORTA, NODES), REAL TIME WITH	X
76775	ULTRASOUND, RETROPERITONEAL (EG, RENAL, AORTA, NODES), B-SCAN AND/OR	X
76776	ULTRASOUND, TRANSPLANTED KIDNEY, REAL TIME AND DUPLEX DOPPLER WITH	X
76800	ULTRASOUND, SPINAL CANAL AND CONTENTS	X
76801	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION,	X
76802	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION,	X
76805	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION,	X
76810	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION,	X
76811	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION,	X
76812	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION,	X
76815	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION,	X
76816	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION,	X
76817	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION,	X
76818	FETAL BIOPHYSICAL PROFILE; WITH NON-STRESS TESTING	X
76819	FETAL BIOPHYSICAL PROFILE; WITHOUT NON-STRESS TESTING	X
76825	ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, REAL TIME WITH IMAGE	X
76826	ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, REAL TIME WITH IMAGE	X
76827	DOPPLER ECHOCARDIOGRAPHY, FETAL, PULSED WAVE AND/OR CONTINUOUS WAVE	X
76828	DOPPLER ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, PULSED WAVE	X
76830	ULTRASOUND, TRANSVAGINAL	X
76831	SALINE INFUSION SONOHYSTEROGRAPHY (SIS), INCLUDING COLOR FLOW	X
76856	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE	X
76857	ULTRASOUND, PELVIC (NONOBSTETRIC), B-SCAN AND/OR REAL TIME WITH IMAGE	X
76870	ULTRASOUND, SCROTUM AND CONTENTS	X
76872	ULTRASOUND, TRANSRECTAL	X
76873	ULTRASOUND, TRANSRECTAL PROSTATE VOLUME STUDY FOR BRACHYTHERAPY	X
76880	ULTRASOUND, EXTREMITY, NONVASCULAR, REAL TIME WITH IMAGE	X
76885	ULTRASOUND, INFANT HIPS, REAL TIME WITH IMAGING DOCUMENTATION;	X
76886	ULTRASOUND, INFANT HIPS, REAL TIME WITH IMAGING DOCUMENTATION;	X
76930	ULTRASONIC GUIDANCE FOR PERICARDIOCENTESIS, IMAGING SUPERVISION AND	X
76932	ULTRASONIC GUIDANCE FOR ENDOMYOCARDIAL BIOPSY, IMAGING SUPERVISION	X
76936	ULTRASOUND GUIDED COMPRESSION REPAIR OF ARTERIAL PSEUDOANEURYSM OR	X
76937	ULTRASOUND GUIDANCE FOR VASCULAR ACCESS REQUIRING ULTRASOUND	X
76940	ULTRASOUND GUIDANCE FOR, AND MONITORING OF, PARENCHYMAL TISSUE	X
76941	ULTRASONIC GUIDANCE FOR INTRAUTERINE FETAL TRANSFUSION OR	X
76942	ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION,	X
76945	ULTRASONIC GUIDANCE FOR CHORIONIC VILLUS SAMPLING, IMAGING	X
76946	ULTRASONIC GUIDANCE FOR AMNIOCENTESIS, IMAGING SUPERVISION AND	X
76948	ULTRASONIC GUIDANCE FOR ASPIRATION OF OVA, IMAGING SUPERVISION AND	X
76950	ULTRASONIC GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS	X
76965	ULTRASONIC GUIDANCE FOR INTERSTITIAL RADIOELEMENT APPLICATION	X
76970	ULTRASOUND STUDY FOLLOW-UP (SPECIFY)	X
76975	GASTROINTESTINAL ENDOSCOPIC ULTRASOUND, SUPERVISION AND	X
76977	ULTRASOUND BONE DENSITY MEASUREMENT AND INTERPRETATION, PERIPHERAL	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
76998	ULTRASONIC GUIDANCE, INTRAOPERATIVE	X
76999	UNLISTED ULTRASOUND PROCEDURE (EG, DIAGNOSTIC, INTERVENTIONAL)	X
77011	COMPUTED TOMOGRAPHY GUIDANCE FOR STEREOTACTIC LOCALIZATION	X
77012	COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY,	X
77014	COMPUTED TOMOGRAPHY GUIDANCE FOR PLACEMENT OF RADIATION THERAPY	X
77021	MAGNETIC RESONANCE GUIDANCE FOR NEEDLE PLACEMENT (EG, FOR BIOPSY,	X
77022	MAGNETIC RESONANCE GUIDANCE FOR, AND MONITORING OF, PARENCHYMAL	X
77055	MAMMOGRAPHY; UNILATERAL	X
77056	MAMMOGRAPHY; BILATERAL	X
77057	SCREENING MAMMOGRAPHY, BILATERAL (2-VIEW FILM STUDY OF EACH BREAST)	X
77058	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST	X
77059	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST	X
77078	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES;	X
77079	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES;	X
77080	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE	X
77081	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE	X
77083	RADIOGRAPHIC ABSORPTIOMETRY (EG, PHOTODENSITOMETRY, RADIOGRAMMETRY),	X
77084	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BONE MARROW BLOOD SUPPLY	X
78350	BONE DENSITY (BONE MINERAL CONTENT) STUDY, ONE OR MORE SITES; SINGLE	X
78351	BONE DENSITY (BONE MINERAL CONTENT) STUDY, ONE OR MORE SITES; DUAL	X
78459	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC	X
78464	MYOCARDIAL PERFUSION IMAGING; TOMOGRAPHIC (SPECT), SINGLE STUDY	X
78465	MYOCARDIAL PERFUSION IMAGING; TOMOGRAPHIC (SPECT), MULTIPLE STUDIES	X
78478	MYOCARDIAL PERFUSION STUDY WITH WALL MOTION, QUALITATIVE OR	X
78480	MYOCARDIAL PERFUSION STUDY WITH EJECTION FRACTION (LIST SEPARATELY IN	X
78491	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION;	X
78492	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION;	X
78608	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); METABOLIC	X
78609	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); PERFUSION	X
78811	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); LIMITED AREA (EG,	X
78812	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); SKULL BASE TO	X
78813	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); WHOLE BODY	X
78814	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY	X
78815	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY	X
78816	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY	X
90655	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, WHEN	X
90656	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, WHEN	X
90723	DIPHTHERIA, TETANUS TOXOIDS, ACELLULAR PERTUSSIS VACCINE, HEPATITIS	X
90747	HEPATITIS B VACCINE, DIALYSIS OR IMMUNOSUPPRESSED PATIENT DOSAGE (4	X
91055	GASTRIC INTUBATION, WASHINGS, AND PREPARING SLIDES FOR CYTOLOGY	X
92506	EVALUATION OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR	X
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR AUDITORY	X
92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR AUDITORY	X
92977	THROMBOLYSIS, CORONARY; BY INTRAVENOUS INFUSION	X
92978	INTRAVASCULAR ULTRASOUND (CORONARY VESSEL OR GRAFT) DURING DIAGNOSTIC	X
93303	TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES;	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
93304	TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES;	X
93306	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION	X
93307	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION	X
93308	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION	X
93312	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE DOCUMENTATION	X
93313	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE DOCUMENTATION	X
93314	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE DOCUMENTATION	X
93315	TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES;	X
93316	TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES;	X
93317	TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES;	X
93318	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL (TEE) FOR MONITORING PURPOSES,	X
93320	DOPPLER ECHOCARDIOGRAPHY, PULSED WAVE AND/OR CONTINUOUS WAVE WITH	X
93321	DOPPLER ECHOCARDIOGRAPHY, PULSED WAVE AND/OR CONTINUOUS WAVE WITH	X
93325	DOPPLER ECHOCARDIOGRAPHY COLOR FLOW VELOCITY MAPPING (LIST SEPARATELY	X
93350	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION	X
93351	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION	X
93352	USE OF ECHOCARDIOGRAPHIC CONTRAST AGENT DURING STRESS	X
93571	INTRAVASCULAR DOPPLER VELOCITY AND/OR PRESSURE DERIVED CORONARY FLOW	X
93572	INTRAVASCULAR DOPPLER VELOCITY AND/OR PRESSURE DERIVED CORONARY FLOW	X
93875	NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTRACRANIAL ARTERIES, COMPLETE	X
93880	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; COMPLETE BILATERAL STUDY	X
93882	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; UNILATERAL OR LIMITED STUDY	X
93886	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES; COMPLETE	X
93888	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES; LIMITED	X
93922	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY	X
93923	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY	X
93924	NON-INVASIVE PHYSIOLOGIC STUDIES OF LOWER EXTREMITY ARTERIES, AT REST	X
93925	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS;	X
93926	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS;	X
93930	DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS;	X
93931	DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS;	X
93970	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND	X
93971	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND	X
93975	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL,	X
93976	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL,	X
93978	DUPLEX SCAN OF AORTA, INFERIOR VENA CAVA, ILIAC VASCULATURE, OR	X
93979	DUPLEX SCAN OF AORTA, INFERIOR VENA CAVA, ILIAC VASCULATURE, OR	X
93980	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF PENILE VESSELS;	X
93981	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF PENILE VESSELS;	X
93990	DUPLEX SCAN OF HEMODIALYSIS ACCESS (INCLUDING ARTERIAL INFLOW, BODY	X
95930	VISUAL EVOKED POTENTIAL (VEP) TESTING CENTRAL NERVOUS SYSTEM,	X
96360	INTRAVENOUS INFUSION, HYDRATION; INITIAL, 31 MINUTES TO 1 HOUR	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
96361	INTRAVENOUS INFUSION, HYDRATION; EACH ADDITIONAL HOUR (LIST	X
96365	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY	X
96366	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY	X
96367	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY	X
96369	SUBCUTANEOUS INFUSION FOR THERAPY OR PROPHYLAXIS (SPECIFY SUBSTANCE	X
96370	SUBCUTANEOUS INFUSION FOR THERAPY OR PROPHYLAXIS (SPECIFY SUBSTANCE	X
96371	SUBCUTANEOUS INFUSION FOR THERAPY OR PROPHYLAXIS (SPECIFY SUBSTANCE	X
96372	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE	X
96373	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE	X
96374	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE	X
96375	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE	X
96376	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE	X
96401	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR;	X
96402	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR; HORMONAL	X
96409	CHEMOTHERAPY ADMINISTRATION; INTRAVENOUS, PUSH TECHNIQUE, SINGLE OR	X
96413	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; UP TO 1	X
96415	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; EACH	X
96416	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE;	X
96417	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; EACH	X
96420	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; PUSH TECHNIQUE	X
96422	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, UP	X
96423	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, EACH	X
96425	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE,	X
97001	PHYSICAL THERAPY EVALUATION	X
97002	PHYSICAL THERAPY RE-EVALUATION	X
97003	OCCUPATIONAL THERAPY EVALUATION	X
97004	OCCUPATIONAL THERAPY RE-EVALUATION	X
97005	ATHLETIC TRAINING EVALUATION	X
97006	ATHLETIC TRAINING RE-EVALUATION	X
97010	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HOT OR COLD PACKS	X
97012	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; TRACTION, MECHANICAL	X
97014	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL	X
97016	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; VASOPNEUMATIC DEVICES	X
97018	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; PARAFFIN BATH	X
97022	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; WHIRLPOOL	X
97024	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; DIATHERMY (EG,	X
97026	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; INFRARED	X
97028	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRAVIOLET	X
97032	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL	X
97033	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; IONTOPHORESIS, EACH	X
97034	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; CONTRAST BATHS, EACH	X
97035	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRASOUND, EACH 15	X
97036	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HUBBARD TANK, EACH 15	X
97039	UNLISTED MODALITY (SPECIFY TYPE AND TIME IF CONSTANT ATTENDANCE)	X
97110	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES;	X
97112	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES;	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
97113	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; AQUATIC	X
97116	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; GAIT	X
97124	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; MASSAGE,	X
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL	X
97530	THERAPEUTIC ACTIVITIES, DIRECT (ONE ON ONE) PATIENT CONTACT BY THE	X
97533	SENSORY INTEGRATIVE TECHNIQUES TO ENHANCE SENSORY PROCESSING AND	X
97545	WORK HARDENING/CONDITIONING; INITIAL 2 HOURS	X
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT (EG, MUSCULOSKELETAL,	X
97761	PROSTHETIC TRAINING, UPPER AND/OR LOWER EXTREMITY(S), EACH 15 MINUTES	X
97799	UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE	X
99201	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF	X
99202	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF	X
99203	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF	X
99204	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF	X
99205	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF	X
99211	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF	X
99212	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF	X
99213	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF	X
99214	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF	X
99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF	X
A4641	RADIOPHARMACEUTICAL, DIAGNOSTIC, NOT OTHERWISE CLASSIFIED	X
A4642	INDIUM IN-111 SATUMOMAB PENDETIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO	X
A9500	TECHNETIUM TC-99M SESTAMIBI, DIAGNOSTIC, PER STUDY DOSE, UP TO 40	X
A9502	TECHNETIUM TC-99M TETROFOSMIN, DIAGNOSTIC, PER STUDY DOSE	X
A9503	TECHNETIUM TC-99M MEDRONATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 30	X
A9504	TECHNETIUM TC-99M APCITIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 20	X
A9505	THALLIUM TL-201 THALLOUS CHLORIDE, DIAGNOSTIC, PER MILLICURIE	X
A9507	INDIUM IN-111 CAPROMAB PENDETIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO	X
A9508	IODINE I-131 IOBENGUANE SULFATE, DIAGNOSTIC, PER 0.5 MILLICURIE	X
A9510	TECHNETIUM TC-99M DISOFENIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 15	X
A9546	COBALT CO-57/58, CYANOCOBALAMIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 1	X
A9550	TECHNETIUM TC-99M SODIUM GLUCEPTATE, DIAGNOSTIC, PER STUDY DOSE, UP	X
A9556	GALLIUM GA-67 CITRATE, DIAGNOSTIC, PER MILLICURIE	X
A9557	TECHNETIUM TC-99M BICISATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 25	X
A9558	XENON XE-133 GAS, DIAGNOSTIC, PER 10 MILLICURIES	X
A9560	TECHNETIUM TC-99M LABELED RED BLOOD CELLS, DIAGNOSTIC, PER STUDY	X
A9561	TECHNETIUM TC-99M OXIDRONATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 30	X
A9562	TECHNETIUM TC-99M MERTIATIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 15	X
A9563	SODIUM PHOSPHATE P-32, THERAPEUTIC, PER MILLICURIE	X
A9564	CHROMIC PHOSPHATE P-32 SUSPENSION, THERAPEUTIC, PER MILLICURIE	X
A9580	SODIUM FLUORIDE F-18, DIAGNOSTIC, PER STUDY DOSE, UP TO 30	X
A9605	SAMARIUM SM-153 LEXIDRONAMM, THERAPEUTIC, PER 50 MILLICURIES	X
A9700	SUPPLY OF INJECTABLE CONTRAST MATERIAL FOR USE IN ECHOCARDIOGRAPHY,	X
C8900	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, ABDOMEN	X
C8901	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, ABDOMEN	X
C8902	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH	X
C8903	MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST; UNILATERAL	X



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C8904	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST; UNILATERAL	X
C8905	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST FOLLOWED BY WITH	X
C8906	MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST; BILATERAL	X
C8907	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST; BILATERAL	X
C8908	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST FOLLOWED BY WITH	X
C8909	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, CHEST (EXCLUDING	X
C8910	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, CHEST (EXCLUDING	X
C8911	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH	X
C8912	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, LOWER EXTREMITY	X
C8913	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, LOWER EXTREMITY	X
C8914	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH	X
C8918	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, PELVIS	X
C8919	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, PELVIS	X
C8920	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH	X
C8921	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST	X
C8922	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST	X
C8923	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST	X
C8924	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST	X
C8925	TRANSESOPHAGEAL ECHOCARDIOGRAPHY (TEE) WITH CONTRAST, OR WITHOUT	X
C8926	TRANSESOPHAGEAL ECHOCARDIOGRAPHY (TEE) WITH CONTRAST, OR WITHOUT	X
C8927	TRANSESOPHAGEAL ECHOCARDIOGRAPHY (TEE) WITH CONTRAST, OR WITHOUT	X
C8928	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST	X
C8929	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST	X
C8930	TRANSTHORACIC ECHOCARDIOGRAPHY, WITH CONTRAST, OR WITHOUT CONTRAST	X
C9247	IOBENGUANE, I-123, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MILLICURIES	X
G0166	EXTERNAL COUNTERPULSATION, PER TREATMENT SESSION	X
G0202	SCREENING MAMMOGRAPHY, PRODUCING DIRECT DIGITAL IMAGE, BILATERAL, ALL	X
G0204	DIAGNOSTIC MAMMOGRAPHY, PRODUCING DIRECT DIGITAL IMAGE, BILATERAL,	X
G0206	DIAGNOSTIC MAMMOGRAPHY, PRODUCING DIRECT DIGITAL IMAGE, UNILATERAL,	X
G0219	PET IMAGING WHOLE BODY; MELANOMA FOR NON-COVERED INDICATIONS	X
G0235	PET IMAGING, ANY SITE, NOT OTHERWISE SPECIFIED	X
G0237	THERAPEUTIC PROCEDURES TO INCREASE STRENGTH OR ENDURANCE OF	X
G0238	THERAPEUTIC PROCEDURES TO IMPROVE RESPIRATORY FUNCTION, OTHER THAN	X
G0239	THERAPEUTIC PROCEDURES TO IMPROVE RESPIRATORY FUNCTION OR INCREASE	X
G0252	PET IMAGING, FULL AND PARTIAL-RING PET SCANNERS ONLY, FOR INITIAL	X
G0259	INJECTION PROCEDURE FOR SACROILIAC JOINT; ARTHROGRAPY	X
G0260	INJECTION PROCEDURE FOR SACROILIAC JOINT; PROVISION OF ANESTHETIC,	X
G0268	REMOVAL OF IMPACTED CERUMEN (ONE OR BOTH EARS) BY PHYSICIAN ON SAME	X
J0133	INJECTION, ACYCLOVIR, 5 MG	X
J0150	INJECTION, ADENOSINE FOR THERAPEUTIC USE, 6 MG (NOT TO BE USED TO	X
J0152	INJECTION, ADENOSINE FOR DIAGNOSTIC USE, 30 MG (NOT TO BE USED TO	X
J0170	INJECTION, ADRENALIN, EPINEPHRINE, UP TO 1 ML AMPULE	X
J0295	INJECTION, AMPICILLIN SODIUM/SULBACTAM SODIUM, PER 1.5 GM	X
J0330	INJECTION, SUCCINYLCHOLINE CHLORIDE, UP TO 20 MG	X
J0636	INJECTION, CALCITRIOL, 0.1 MCG	X
J0640	INJECTION, LEUCOVORIN CALCIUM, PER 50 MG	X
J0690	INJECTION, CEFZOLIN SODIUM, 500 MG	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
J0694	INJECTION, CEFOXITIN SODIUM, 1 GM	X
J0696	INJECTION, CEFTRIAZONE SODIUM, PER 250 MG	X
J0881	INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (NON-ESRD USE)	X
J0882	INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (FOR ESRD ON DIALYSIS)	X
J0885	INJECTION, EPOETIN ALFA, (FOR NON-ESRD USE), 1000 UNITS	X
J0886	INJECTION, EPOETIN ALFA, 1000 UNITS (FOR ESRD ON DIALYSIS)	X
J1020	INJECTION, METHYLPREDNISOLONE ACETATE, 20 MG	X
J1030	INJECTION, METHYLPREDNISOLONE ACETATE, 40 MG	X
J1040	INJECTION, METHYLPREDNISOLONE ACETATE, 80 MG	X
J1100	INJECTION, DEXAMETHASONE SODIUM PHOSPHATE, 1MG	X
J1170	INJECTION, HYDROMORPHONE, UP TO 4 MG	X
J1200	INJECTION, DIPHENHYDRAMINE HCL, UP TO 50 MG	X
J1245	INJECTION, DIPYRIDAMOLE, PER 10 MG	X
J1260	INJECTION, DOLASETRON MESYLATE, 10 MG	X
J1265	INJECTION, DOPAMINE HCL, 40 MG	X
J1327	INJECTION, EPTIFIBATIDE, 5 MG	X
J1440	INJECTION, FILGRASTIM (G-CSF), 300 MCG	X
J1441	INJECTION, FILGRASTIM (G-CSF), 480 MCG	X
J1561	INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED	X
J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER),	X
J1568	INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED	X
J1569	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS,	X
J1572	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA/FLEBOGAMMA DIF), INTRAVENOUS,	X
J1580	INJECTION, GARAMYCIN, GENTAMICIN, UP TO 80 MG	X
J1626	INJECTION, GRANISETRON HYDROCHLORIDE, 100 MCG	X
J1642	INJECTION, HEPARIN SODIUM, (HEPARIN LOCK FLUSH), PER 10 UNITS	X
J1644	INJECTION, HEPARIN SODIUM, PER 1000 UNITS	X
J1650	INJECTION, ENOXAPARIN SODIUM, 10 MG	X
J1745	INJECTION INFLIXIMAB, 10 MG	X
J1756	INJECTION, IRON SUCROSE, 1 MG	X
J1790	INJECTION, DROPERIDOL, UP TO 5 MG	X
J1885	INJECTION, KETOROLAC TROMETHAMINE, PER 15 MG	X
J1950	INJECTION, LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), PER 3.75 MG	X
J1956	INJECTION, LEVOFLOXACIN, 250 MG	X
J2001	INJECTION, LIDOCAINE HCL FOR INTRAVENOUS INFUSION, 10 MG	X
J2060	INJECTION, LORAZEPAM, 2 MG	X
J2175	INJECTION, MEPERIDINE HYDROCHLORIDE, PER 100 MG	X
J2180	INJECTION, MEPERIDINE AND PROMETHAZINE HCL, UP TO 50 MG	X
J2250	INJECTION, MIDAZOLAM HYDROCHLORIDE, PER 1 MG	X
J2270	INJECTION, MORPHINE SULFATE, UP TO 10 MG	X
J2275	INJECTION, MORPHINE SULFATE (PRESERVATIVE-FREE STERILE SOLUTION), PER	X
J2300	INJECTION, NALBUPHINE HYDROCHLORIDE, PER 10 MG	X
J2355	INJECTION, OPRELVEKIN, 5 MG	X
J2405	INJECTION, ONDANSETRON HYDROCHLORIDE, PER 1 MG	X
J2430	INJECTION, PAMIDRONATE DISODIUM, PER 30 MG	X
J2469	INJECTION, PALONOSETRON HCL, 25 MCG	X
J2501	INJECTION, PARICALCITOL, 1 MCG	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
J2505	INJECTION, PEGFILGRASTIM, 6 MG	X
J2550	INJECTION, PROMETHAZINE HCL, UP TO 50 MG	X
J2710	INJECTION, NEOSTIGMINE METHYLSULFATE, UP TO 0.5 MG	X
J2765	INJECTION, METOCLOPRAMIDE HCL, UP TO 10 MG	X
J2780	INJECTION, RANITIDINE HYDROCHLORIDE, 25 MG	X
J2790	INJECTION, RHO D IMMUNE GLOBULIN, HUMAN, FULL DOSE, 300 MICROGRAMS	X
J2791	INJECTION, RHO(D) IMMUNE GLOBULIN (HUMAN), (RHOPHYLAC), INTRAMUSCULAR	X
J2820	INJECTION, SARGRAMOSTIM (GM-CSF), 50 MCG	X
J2993	INJECTION, RETEPLASE, 18.1 MG	X
J2995	INJECTION, STREPTOKINASE, PER 250,000 IU	X
J2997	INJECTION, ALTEPLASE RECOMBINANT, 1 MG	X
J3010	INJECTION, FENTANYL CITRATE, 0.1 MG	X
J3285	INJECTION, TREPROSTINIL, 1 MG	X
J3301	INJECTION, TRIAMCINOLONE ACETONIDE, NOT OTHERWISE SPECIFIED, 10 MG	X
J3370	INJECTION, VANCOMYCIN HCL, 500 MG	X
J3410	INJECTION, HYDROXYZINE HCL, UP TO 25 MG	X
J3420	INJECTION, VITAMIN B-12 CYANOCOBALAMIN, UP TO 1000 MCG	X
J3430	INJECTION, PHYTONADIONE (VITAMIN K), PER 1 MG	X
J3480	INJECTION, POTASSIUM CHLORIDE, PER 2 MEQ	X
J3487	INJECTION, ZOLEDRONIC ACID (ZOMETA), 1 MG	X
J3488	INJECTION, ZOLEDRONIC ACID (RECLAST), 1 MG	X
J7030	INFUSION, NORMAL SALINE SOLUTION , 1000 CC	X
J7040	INFUSION, NORMAL SALINE SOLUTION, STERILE (500 ML=1 UNIT)	X
J7042	5% DEXTROSE/NORMAL SALINE (500 ML = 1 UNIT)	X
J7050	INFUSION, NORMAL SALINE SOLUTION , 250 CC	X
J7060	5% DEXTROSE/WATER (500 ML = 1 UNIT)	X
J7120	RINGERS LACTATE INFUSION, UP TO 1000 CC	X
J7642	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED	X
J9000	INJECTION, DOXORUBICIN HYDROCHLORIDE, 10 MG	X
J9015	INJECTION, ALDESLEUKIN, PER SINGLE USE VIAL	X
J9020	INJECTION, ASPARAGINASE, 10,000 UNITS	X
J9031	BCG (INTRAVESICAL) PER INSTILLATION	X
J9035	INJECTION, BEVACIZUMAB, 10 MG	X
J9040	INJECTION, BLEOMYCIN SULFATE, 15 UNITS	X
J9045	INJECTION, CARBOPLATIN, 50 MG	X
J9055	INJECTION, CETUXIMAB, 10 MG	X
J9060	CISPLATIN, POWDER OR SOLUTION, PER 10 MG	X
J9062	CISPLATIN, 50 MG	X
J9070	CYCLOPHOSPHAMIDE, 100 MG	X
J9093	CYCLOPHOSPHAMIDE, LYOPHILIZED, 100 MG	X
J9096	CYCLOPHOSPHAMIDE, LYOPHILIZED, 1.0 GRAM	X
J9100	INJECTION, CYTARABINE, 100 MG	X
J9120	INJECTION, DACTINOMYCIN, 0.5 MG	X
J9130	DACARBAZINE, 100 MG	X
J9170	INJECTION, DOCETAXEL, 20 MG	X
J9181	INJECTION, ETOPOSIDE, 10 MG	X



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<u>CD</u>	<u>DS</u>	<u>ADDON</u>
J9185	INJECTION, FLUDARABINE PHOSPHATE, 50 MG	X
J9190	INJECTION, FLUOROURACIL, 500 MG	X
J9201	INJECTION, GEMCITABINE HYDROCHLORIDE, 200 MG	X
J9202	GOSERELIN ACETATE IMPLANT, PER 3.6 MG	X
J9206	INJECTION, IRINOTECAN, 20 MG	X
J9209	INJECTION, MESNA, 200 MG	X
J9214	INJECTION, INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS	X
J9217	LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 7.5 MG	X
J9218	LEUPROLIDE ACETATE, PER 1 MG	X
J9263	INJECTION, OXALIPLATIN, 0.5 MG	X
J9265	INJECTION, PACLITAXEL, 30 MG	X
J9270	INJECTION, PLICAMYCIN, 2.5 MG	X
J9280	MITOMYCIN, 5 MG	X
J9293	INJECTION, MITOXANTRONE HYDROCHLORIDE, PER 5 MG	X
J9310	INJECTION, RITUXIMAB, 100 MG	X
J9320	INJECTION, STREPTOZOCIN, 1 GRAM	X
J9350	INJECTION, TOPOTECAN, 4 MG	X
J9355	INJECTION, TRASTUZUMAB, 10 MG	X
J9360	INJECTION, VINBLASTINE SULFATE, 1 MG	X
J9370	VINCRISTINE SULFATE, 1 MG	X
J9375	VINCRISTINE SULFATE, 2 MG	X
J9390	INJECTION, VINOURELBINE TARTRATE, 10 MG	X
Q0081	INFUSION THERAPY, USING OTHER THAN CHEMOTHERAPEUTIC DRUGS, PER VISIT	X
Q0083	CHEMOTHERAPY ADMINISTRATION BY OTHER THAN INFUSION TECHNIQUE ONLY (EG	X
Q0084	CHEMOTHERAPY ADMINISTRATION BY INFUSION TECHNIQUE ONLY, PER VISIT	X
Q0085	CHEMOTHERAPY ADMINISTRATION BY BOTH INFUSION TECHNIQUE AND OTHER	X
Q3014	TELEHEALTH ORIGINATING SITE FACILITY FEE	X
Q9954	ORAL MAGNETIC RESONANCE CONTRAST AGENT, PER 100 ML	X
Q9965	LOW OSMOLAR CONTRAST MATERIAL, 100-199 MG/ML IODINE CONCENTRATION,	X
Q9966	LOW OSMOLAR CONTRAST MATERIAL, 200-299 MG/ML IODINE CONCENTRATION,	X
Q9967	LOW OSMOLAR CONTRAST MATERIAL, 300-399 MG/ML IODINE CONCENTRATION,	X
S0310	HOSPITALIST SERVICES (LIST SEPARATELY IN ADDITION TO CODE FOR	X
S8035	MAGNETIC SOURCE IMAGING	X
S8037	MAGNETIC RESONANCE CHOLANGIOPANCREATOGRAPHY (MRCP)	X
S8040	TOPOGRAPHIC BRAIN MAPPING	X
S8042	MAGNETIC RESONANCE IMAGING (MRI), LOW-FIELD	X
S8080	SCINTIMAMMOGRAPHY (RADIOIMMUNOSCINTIGRAPHY OF THE BREAST),	X
S8085	FLUORINE-18 FLUORODEOXYGLUCOSE (F-18 FDG) IMAGING USING DUAL-HEAD	X
S8092	ELECTRON BEAM COMPUTED TOMOGRAPHY (ALSO KNOWN AS ULTRAFASCT, CINE	X
S9090	VERTEBRAL AXIAL DECOMPRESSION, PER SESSION	X
S9152	SPEECH THERAPY, RE-EVALUATION	X
T1502	ADMINISTRATION OF ORAL, INTRAMUSCULAR AND/OR SUBCUTANEOUS MEDICATION	X



## CLAIM LEVEL PAYMENTS

There are some procedures indicated on the Blue Cross MAP listing that are reimbursed at the claim level. What this means is that when a claim is submitted with that particular CPT code, the claim will be reimbursed at the MAP rate **for all services on that claim**, EXCEPT THOSE THAT HAVE ADD-ON MAPS.

This can create problems for providers when series accounts are being billed. An example would be services provided for wound care. If a claim is billed for multiple days with CPT code 15340 for application of a skin substitute, rather than the system paying on each day, it will pay at the claim level or the MAP for that code. This could make a considerable difference in the reimbursement received for this type of care.

Review the MAP listing and make special note of those services paid at the claim level. Following is only an example of the indication of claim level codes.

PROC	HCPCS	UNIT	CLM
CD	DS	LIMIT	LVL SURG
10060	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE	-	X
10061	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE	-	X
10080	INCISION AND DRAINAGE OF PILONIDAL CYST; SIMPLE	-	X
10081	INCISION AND DRAINAGE OF PILONIDAL CYST; COMPLICATED	-	X
10120	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; SIMPLE	-	X
10121	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES;	-	X
10140	INCISION AND DRAINAGE OF HEMATOMA, SEROMA OR FLUID COLLECTION	-	X
10160	PUNCTURE ASPIRATION OF ABSCESS, HEMATOMA, BULLA, OR CYST	-	X
10180	INCISION AND DRAINAGE, COMPLEX, POSTOPERATIVE WOUND INFECTION	-	X
11055	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR	-	X
11056	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR	-	X
11057	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR	-	X
	BIOPSY OF SKIN, SUBCUTANEOUS TISSUE AND/OR MUCOUS MEMBRANE		
11100	(INCLUDING	-	X
11200	REMOVAL OF SKIN TAGS, MULTIPLE FIBROSCUTANEOUS TAGS, ANY AREA; UP TO	-	X
11300	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR	-	X



## INFUSIONS/INJECTIONS

There are a number of facilities that are still having problems with billing infusions and injections when provided in the treatment area (0761), ER (0450) and observation (0762).

Make note of the particular codes below that indicate INITIAL and develop a process that will eliminate the possibility of billing more than one initial code unless protocol requires that two separate IV sites must be used, or when multiple encounters occur on the same day. A multiple encounter occurs when the patient is treated, leaves the facility, and returns on the same day.

Codes marked with an **asterisk\* have a unit value of 1** in the Blue Cross system meaning that we will pay only one MAP per encounter for that code. Example would be if you billed 96361 with a unit value of 4 indicating that you had 4 additional hours of hydration therapy, we would pay only ONE additional hour at the MAP rate.

### 2009 CPT codes and descriptions for drug administration

#### *HYDRATION ADMINISTRATION*

<b>96360</b>	Intravenous infusion, <b>hydration, INITIAL</b> , 31 minutes to 1 hour
<b>96361</b>	Intravenous infusion, <b>hydration; each additional hour</b> (List separately in addition to code for primary procedure)

***THERAPEUTIC, PROPHYLACTIC, DIAGNOSTIC ADMINISTRATION CODES***

<b>*96365</b>	<b>Intravenous infusion</b> , for therapy, prophylaxis, or diagnosis (specify substance or drug): <b>INITIAL</b> , up to 1 hour
<b>*96366</b>	<b>Intravenous infusion</b> , for therapy, prophylaxis, or diagnosis (specify substance or drug); <b>each additional hour</b> (List separately in addition to code for primary procedure)
<b>*96367</b>	<b>Intravenous infusion</b> , for therapy, prophylaxis, or diagnosis (specify substance or drug); additional <b>sequential infusion</b> , up to 1 hour (List separately in addition to code for primary procedure)
<b>*96368</b>	<b>Intravenous infusion</b> , for therapy, prophylaxis, or diagnosis (specify substance or drug); <b>concurrent infusion</b> (List separately in addition to code for primary procedure)
<b>*96369</b>	<b>Subcutaneous infusion</b> for therapy or prophylaxis (specify substance or drug) <b>INITIAL</b> , up to one hour, including pump set up and establishment of subcutaneous infusion site (s)
<b>*96370</b>	<b>Subcutaneous infusion</b> for therapy or prophylaxis (specify substance or drug); <b>each additional hour</b> (List separately in addition to code for primary procedure)
<b>*96371</b>	<b>Subcutaneous infusion</b> for therapy or prophylaxis (specify substance or drug); <b>additional pump set-up</b> with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)
<b>96372</b>	Therapeutic, prophylactic, or diagnostic <b>injection</b> (specify substance or drug); <b>subcutaneous or intramuscular(SQ/IM)</b>
<b>96373</b>	Therapeutic, prophylactic, or diagnostic <b>injection</b> (specify substance or drug); <b>intra-arterial</b>
<b>96374</b>	Therapeutic, prophylactic or diagnostic injection (specify substance or drug) <b>intravenous push</b> , single or <b>INITIAL</b> substance/drug
<b>96375</b>	Each additional <b>subsequent intravenous push</b> of a new substance/drug

***THERAPEUTIC, PROPHYLACTIC, DIAGNOSTIC ADMINISTRATION CODES cont.***

<b>*96376</b>	Each additional <b>sequential intravenous push</b> of the same substance/drug <b>provided in a facility</b>
<b>96379</b>	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion
<b>C8957</b>	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump

**CHEMOTHERAPY AND OTHER HIGHLY COMPLEX DRUG ADMINISTRATION CODES AND DESCRIPTIONS**

- Highly complex drugs are defined as:
  - anti-neoplastic agents for noncancerous diagnoses
  - monoclonal antibody agents
  - nonradionuclide antineoplastic drugs
  - other biologic response modifiers

<b>96401</b>	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
<b>96402</b>	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic
<b>96405</b>	Chemotherapy administration; intralesional, up to and including 7 lesions
<b>96406</b>	Chemotherapy administration; intralesional, more than 7 lesions
<b>*96409</b>	Chemotherapy administration; intravenous, push technique, single or initial substance/drug
<b>96411</b>	Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)
<b>*96413</b>	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
<b>96415</b>	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)
<b>*96416</b>	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump
<b>96417</b>	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)
<b>*96420</b>	Chemotherapy administration, intra-arterial; push technique
<b>*96422</b>	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour
<b>96423</b>	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)
<b>*96425</b>	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
<b>96440</b>	Chemotherapy administration into pleural cavity, requiring and including thoracentesis
<b>96445</b>	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis
<b>96450</b>	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture
<b>96542</b>	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents

**OTHER INJECTION AND INFUSION SERVICES CODES PER CPT INSTRUCTIONS, 96521-96523 MAY BE REPORTED WHEN THESE DEVICES ARE USED FOR THERAPEUTIC DRUGS OTHER THAN CHEMOTHERAPY**

<b>96521</b>	Refilling and maintenance of portable pump
<b>96522</b>	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)
<b>96523</b>	Irrigation of implanted venous access device for drug delivery systems
<b>C8957</b>	(Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump)

## **Hierarchy Guidelines**

There are problems with following the hierarchy of the services and billing properly. Hospitals should follow this guideline when determining what codes should be billed for infusion/injection services.

First:

- #1 - Chemotherapy services
- #2 - Therapeutic, diagnostic, prophylactic services
- #3 - Hydration

Secondly:

- #1 Infusion
- #2 Push
- #3 Injection

Report both the specific service as well as code(s) for the specific substance(s) or drug(s) provided. The fluid used to administer the drug(s) is considered incidental and a hydration code (96360) is not separately reportable.



## **Initial Therapeutic, Prophylactic or Diagnostic Intravenous infusion**

There could be situations where both hydration and IV infusion of a therapeutic drug are billable on the same claim. The first hour of IV infusion is billed with CPT code 96365 but if the IV hydration was in a different arm, code 96360 would also be billable. The medical records must clearly indicate two different arms or sites were used.

## **Subsequent/Sequential**

Sequential injections or infusions are indicated with codes 96367, 96375, and 96417. If an injection or infusion is of a subsequent nature, even if it is the first service within that group of services, then a subsequent code would be reported. Sequential infusions occur when the one drug is infused then a different drug is infused.

For example, if chemotherapy IV infusion and a therapeutic IV infusion are administered during the same encounter and the same site, the hierarchy states to use the initial code for chemo (96413), then the sequential code for the therapeutic IV (96367) would be reported, even if the therapeutic IV was administered first. Code 96417, 96375, or 96367 would be reported only once per sequential infusion of the same infusate mix. The additional hours of the infusion would be reported under the additional hour code, 96415 or 96366. **An additional IV push of the same drug is reported with CPT code 96376 only when at least 30 minutes has elapsed between each push of the same drug.** This is an area that apparently is hard to monitor as we see this additional billing many times during audits. Please work with staff to assure this time period is observed.

## **Concurrent Infusions**

A concurrent infusion occurs when multiple infusions are given through the same line simultaneously or two separate IV bags are infused at the same time or multiple infusions are provided through the same intravenous line. The appropriate code is 96368 and can be reported only one time per encounter.

**Do not report a concurrent infusion** when the patient receives multiple drugs from the same IV bag. Each substance can be reported separately, but only one administration is reported. Multiple substances mixed in one bag are considered to be one infusion and are not reported as a concurrent infusion.

Fluids administered (96360) concurrently cannot be reported separately. The additional hour hydration code (96361) can be reported if provided as a secondary or subsequent service after a different initial service (96360, 96365, 36374, 96409, and 96413). An example would be if an IV bag of hydration fluids and an IV bag of therapeutic drugs were infusing at the same time through the same line. In this scenario, the administration of hydration fluid cannot be separately reported.

## **Documenting Drug Administration**

The medical records must clearly indicate the start and end time for each infusion. Hospitals should not include in their reporting time that may elapse between establishing vascular access and initiation of the infusion. Specifics of drug administration that would support billing for infusions are; the name of the drug, strength of the drug, method of administration, infusion site and start and stop times. If an IV infusion of a therapeutic drug or chemo drug is indicated, but there is no time documented, the only billable code would be for the administration of an IV push.



## INPATIENT PRE-CERTIFICATIONS

Blue Cross and Blue Shield of Kansas has included in Policies and Procedures, information concerning precertification/continued stay guidelines for inpatient care.

Medical Review Staff has provided information to us indicating there are concerns that not all inpatient stays are being pre-certified timely as well as continued stay reviews are not being handled. This results in a request for complete medical records from hospitals to determine medical necessity.

In the case of continued stay reviews, when a patient is discharged, that information should be noted in the precert system to close the medical management of the inpatient stay. When the discharge date is not completed, these cases remain open and medical review staff must take the appropriate action to determine the outcome of the stay for the insured.

***PLEASE PROVIDE THIS INFORMATION TO THE CASE MANAGEMENT STAFF IN YOUR FACILITIES REMINDING THEM TO ESTABLISH AN INTERNAL PROCESS THAT WILL ASSURE PRE-CERTIFICATIONS ARE DONE TIMELY AS WELL AS DISCHARGE DATES ARE INPUT TO FINALIZE THE PROCESS.***

### **Pre-certification /Continued Stay Review**

The Contracting Provider shall provide notice for all BCBSKS members admitted for inpatient care. This notification will be **required** either

- prior to the admission,
- on the day of admission, or
- first working day following a weekend or holiday.
- acute care hospitals will accomplish this through the electronic pre-certification system.

Through the pre-certification and continued stay review process, the Contracting Provider will be informed when coverage for inpatient admissions and/or continued stays are denied because medical necessity has not been demonstrated.



Appeals procedures for pre-certification and continued stay review are listed in Section V.

In cases where pre-certification is a requirement of a particular employee group and in the event the pre-certification is not obtained, the Contracting Provider may be responsible for any penalties imposed by the group. The Contracting Provider will be informed of any employee group that makes this requirement. When the notice of admission is made, pre-certification for these employee groups is automatically accomplished. Pre-certification and continued stay reviews are conducted to determine the following:

1. Appropriateness of place of treatment, i.e., inpatient, outpatient department, or physician's office
2. Length of stay
3. Admission as inpatient (Certain member contracts require pre-certification.)

If a Company representative experiences discrepancies in information for continued stay reviews or pre-certification, whether telephonic or otherwise, a Company compliance process must be successfully completed by the Contracting Provider to remove or prevent the Contracting Provider from continuing on prepayment reviews. Non-completion of the compliance process falls under Section V of these Policies and Procedures.

## **PRECERTIFICATION PROCESS**

There are three basic steps to the pre-certification process:

1. Initial notification that the patient has been admitted
2. Explanation of why the patient is being admitted
3. Ongoing monitoring of the patient's care

All three parts comprise the patient's stay and determine:

- That the treatment is being provided at the appropriate level of care
- The length of stay is appropriate
- If the hospital stay is medically necessary.



When do I need to initiate the pre-certification?

- Prior to the admission
- On the day of admission
- The first working day following a weekend or holiday

How often do I need to follow-up?

- It depends on the patient's condition and the information available.

Why Pre-certification?

To determine the following:

- Appropriateness of place of treatment, i.e., inpatient, outpatient department, or physician's office
- Length of stay
- Admission as inpatient (Certain member contracts require pre-certification.)

Obstetrical Requirements

The following plans have specific requirements for obstetrical admissions when the mother and/or baby remain hospitalized beyond a certain time.

- Blue Cross and Blue Shield of Kansas
  - 72 hours after a vaginal delivery
  - 96 hours after a cesarean section
- Federal Employee Program (FEP)
  - 48 hours after a vaginal delivery
  - 96 hours after a cesarean section

Note: If the mother or the baby requires a transfer to another hospital, the receiving hospital will need to obtain precertification for the admission.



## ON-LINE PRECERTIFICATION SCREENS

### New Pre-certification

When you need to initiate a new pre-certification, select the option labeled:

**Pre-certification Options**

To create a New Pre-certification request for your patient or to view the status of an Existing Pre-certification request, please select one of the following choices.

**New Pre-certifications**  
(for new procedure/admission)

**Pre-certifications in Process**  
(to review the status of an existing pre-certification,  
for concurrent review or to enter a discharge date)

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### Existing Pre-certification / Pre-certification in Process (also known as....Existing Pre-certification)

HHPre-certification In Process are open/active pre-certifications that still require clinical information in and/or requiring continued stay review. Pre-certifications remain in the Pre-certification in Process until a discharge date has been entered (i.e. the pre-certification has been completed).

Pre-certifications In Process include pre-certifications that are available for:

- Completing the initial pre-certification process by adding clinical information
  - HH• Requesting additional days for extension
  - HH• Submitting a date of discharge (ending the continued stay review process)
- HH  
HH

This screen actually limits the number of pre-certifications to view based on the certified/review date listed. Pre-certifications with a Certified/Review Date will be displayed only through the date listed on this screen.

**Search for Pre-certifications in Process**

Month (mm)    Day (dd)    Year (yyyy)  
       

  

Return to the [Pre-certification Menu](#).

HH

**Note: To see future pre-certifications (e.g. you want to verify the doctor's office pre-certified an upcoming procedure) you can change the date to five (5) days beyond the Expected Admission Date.**

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**Existing Pre-certification**

This list will identify the status of each pre-certification that has not been completed (i.e. the patient has not been discharged). It also lists pre-certifications initiated prior to an admission and the status of those pre-certifications.

To actually see the details of each individual pre-certification, simple use your mouse to click on the **Patient Identification Number**.

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*Note: The Status/Situational Code*

<b>Certified/ Review Date</b>	<b>Patient Identification Number</b>	<b>Patient Name</b>	<b>Status/ Situational Code</b>	<b>Admit Date</b>	<b>Admitting Physician</b>
	<a href="#">555443333</a>	Doo, Scooby	<b>Pended</b>	11/18/03	Seuss, Doctor
	<a href="#">555443333</a>	Doo, Scooby	<b>Pended</b> Medical Review Required	11/19/03	Seuss, Doctor
	<a href="#">555443333</a>	Doo, Scooby	<b>Pended</b> Information Not Received	11/19/03	Seuss, Doctor
11/20/03	<a href="#">555443333</a>	Doo, Scooby	<b>Certified in Total</b>	11/19/03	Seuss, Doctor

**Think of this screen as the case manager's daily workload**

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**Existing Pre-certification**

After double clicking on the Patient Identification Number, the pre-certification form will appear summarizing all the data elements that have been submitted up to this point. At the top of the page will be:

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- The Control Number (Pre-certification Number)
- HH• Date and Time Submitted
- HH• Health Care Services Review Action (Status of the Pre-Certification):

HH

**\* Certified in Total**

This indicates a continued stay review is now required.



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**\* Pended**

This indicates that initial medical criteria has not been submitted.

**\* Pended Requires Medical Review**

The review is awaiting someone from BCBSKS' medical review department to review.

**\* Pended Information Not Received**

This indicates that clinical information was **not** received within two business days. BCBSKS' medical review department will be contacting you.

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If the Pre-certification in Process is **Certified in Total**, then a continued stay review may be required. Sometimes the patient has been discharged, in which case, you merely pull up the pre-certification, scroll down and enter the actual discharge date in the fields provided.

<b>Procedure/Admission Information</b>			
<b>Procedure/Admission Date:</b>	<b>11/14/03</b>		
<b>Procedure/Admission Time:</b>	<b>08:00</b>		
<b>Length of Stay:</b>	<b>002</b>		
<b>Certified/Review Date:</b>	<b>11/16/03</b>		
<b>Facility Type:</b>	<b>Hospital</b>		
<b>Diagnosis Code:</b>	<b>78900</b>		
<b>Procedure Code:</b>			
<b>Procedure Type:</b>	<b>Medical</b>		
<b>Surgical Date:</b>	<b>//</b>		
<b>Admission Type:</b>	<b>Inpatient</b>		
	Month (mm)	Day (dd)	Year (yyyy)
<b>Please Enter the Actual Discharge Date:</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	OR		
<b>Enter the Requested Number of Days for Extension:</b>	<input type="text"/>		

HH

**Existing Pre-certification**

If the patient is still a patient and a continue stay review is due, enter in the number of days you feel the patient will still require in the field:

HH

**Enter the Requested Number of Days for Extension**

**HHNote: After requesting additional days and clicking on Submit (or Enter key on your keyboard) you will be directed to the Medical Criteria screens.**

<b>Enter the Requested Number of Days for Extension:</b> <input type="text"/>
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**Existing Pre-certification**

Every time an update is provided, you have the option of updating the contact information. This information needs to be updated when the person having information on this patient's condition has changed.

**Contact Information**

Contact Name:

Contact Phone: (  )  -

Extension:

Contact E-Mail (Optional):

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## Blue Cross Medical Policies

As you know, BCBSKS publishes medical policies for new and existing procedures throughout the year. Some of the reasons for developing and implementing medical policies include:

- being good stewards of member dollars,
- leveling consistent coverage guidelines to all provider types, and
- proper administration of selected benefit options.

Most medical policies include a listing of covered diagnoses; however, medical justification of a service cannot always be based solely on the diagnosis. Some medical policies also include frequency and utilization guidelines that will require coordination with the ordering physician/practitioner who has knowledge of the patient's medical history. Remember, this same medical policy has also been issued to professional providers so they are aware of the guidelines.

All claims for services associated with a medical policy are reviewed before the claim is finalized. Sometimes medical records are requested to ensure that the services provided meet the criteria in the medical policy. When this is the case, please obtain the needed information and return the letter along with a **new claim** to us. These instructions also apply to claims denied for additional information when indicated as such on a remittance advice (RA). Your remittance advice will reflect a M118 or M58 remark code.

We respectfully ask that providers **do not** indicate "corrected claim" on a new claim being resubmitted because of a denial as outlined above. The only instance when it is appropriate to indicate "corrected claim" on a resubmission is when payment has already been made and the provider discovers the original claim was not filed correctly. Claims that come in marked "corrected claim" are routed through our customer service center for research, which may in turn delay claim adjudication.

Consider such services as MRI of the Breast, Bone Density Studies, CTA of the Chest, etc.....These services will be reviewed on a prepay basis. Please follow the directions in the letters received and submit the specific information with a new claim as noted above. When the claim and the



information is received, our Medical Review Staff will review the records and make a coverage determination. There may be situations when the information being requested, will not be available in the hospital medical record. The referring physician would include the information in his/her medical record. Your facility should develop a process that will allow for obtaining the necessary information so that your claim will be processed as soon as possible.

As you would any situation when you KNOW there is no medical necessity to support providing a specific service as indicated in the medical policy, **submit your initial claim with charges as non-covered on a paper claim along with a NOPFO ([Notice of Personal Financial Obligation](#)) found on our website.** This signed notification will cause the service to be noted as patient responsibility on the remittance advice if it is deemed to be medically unnecessary after the review. Without NOPFO, the denied service will be rejected as a provider contractual write-off.

Please make note of the services your facility might provide and share this information with your staff. You cannot take action on these policies **AFTER** the services are provided to the patient....**THAT IS TOO LATE AND YOUR FACILITY WILL ACCEPT THE CONTRACTUAL WRITE-OFF ON THOSE CHARGES.** Take special note of those policies that have recent updates and assure the changes our made in your "scrubbers" internally.

Providers are encouraged to review our online medical policies ([BCBSKS Medical Policies](#)). Whenever a medical policy is revised or a new policy published, BCBSKS sends out a Web notice (ListServ) to providers. To sign up for ListServ, visit the Web at [http://www.bcbsks.com/Customerservice/Providers/eneews\\_institutional.htm](http://www.bcbsks.com/Customerservice/Providers/eneews_institutional.htm) (see the Reminder handout for a detail copy of this service)



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

## NOTICE OF PERSONAL FINANCIAL OBLIGATION Read Before Signing

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

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

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

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

\_\_\_\_\_  
Date

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

Check one of the following:

- I, \_\_\_\_\_ (witness name), did personally observe the patient/member whose signature appears above and do certify that he/she did read this notice, was given an opportunity to ask questions and did affix his/her signature in my presence.
- Neither the patient nor member was available to sign the Notice of Personal Financial Obligation prior to \_\_\_\_\_ (scheduled start of care date). I, \_\_\_\_\_ (provider representative), did personally inform \_\_\_\_\_ (name of person informed) of the complete details of this notice by telephone on \_\_\_\_\_ (date) and advised him/her that other arrangements would have to be made prior to that date unless he/she agreed to accept personal financial responsibility. They have agreed to sign the notice at the earliest possible time.



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

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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

06/2009



## **SLEEP STUDIES**

Effective Jan 1, 2004, sleep studies and polysomnography services became part of tiered reimbursement. This means that the highest MAP reimbursement for these services (95803, 95805, 95806, 95807, 95808, 95810, 95811) (revenue code 920) are made to providers who have obtained accreditation by the American Academy of Sleep Medicine (AASM).

Medical Review will allow sleep study accreditation from the **Accreditation Commission for Health Care, Inc.** (ACHC) as well as AASM in the near future. The ACHC criteria is more stringent than AASM and is less costly to apply for so we would expect more providers to obtain this accreditation.

## **TESTING FOR VITAMIN D DEFICIENCY**

### **Institutional**

Original Effective Date: August 26, 2009

Revision Date(s): Revision Date(s):

Current Effective Date: August 26, 2009

This is a new medical policy effective August 26, 2009. After pulling reports, we know that there are a large number of providers currently billing for the following CPT codes indicating testing was done:

### **CPT/HCPCS**

82306 Calcifediol (25-OH Vitamin D-3)

82307 Calciferol (Vitamin D)

82652 Dihydroxyvitamin D, 1, 25-

Please provide this information to those involved with scheduling, providing and billing the services to assure that Notice of Financial Obligation (NOPFO) are obtained from the insured prior to the service being done. Physician education would be recommended as well even though health professionals were also notified of this new medical policy.



## GENETIC MOLECULAR TESTING

Genetic Molecular Testing (the analysis of nucleic acids used to diagnose a genetic disease, including but not limited to, sequencing, methylation studies, and linkage analysis) is an excluded service in all Kansas contracts **except the Federal Employee Program (FEP)**.

The member contract defines when GENETIC MOLECULAR TESTING is covered. The exclusion reads as follows: **Genetic Molecular Testing except when there are signs and/or symptoms of an inherited disease in the affected individual, there has been a physical examination, pre-test counseling, and other diagnostic studies, and the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.**

As used herein, "Genetic Molecular Testing", means analysis of nucleic acids used to diagnose a genetic disease, including but not limited to sequencing, methylation studies and linkage analysis.

CPT Codes 83890, 83891, 83892, 83893, 83894, 83896, 83897, 83898, 83901, 83902, 83903, 83904, 83905, 83906 and 83912 (molecular diagnostics) will continue to be By Report and records must be submitted to determine if genetic testing is an eligible benefit. Reimbursement will be available when ALL FOUR of the following prerequisites have been met:

1. Signs and symptoms of an inherited disease have been identified in the individual being tested.
2. A physical examination and other diagnostic studies appropriate to the suspected disease process have been performed prior to genetic molecular testing.
3. Prior to genetic molecular testing, implications of testing and possible treatment options have been explained to the patient by the provider.
4. Confirmation of the suspected disease would remain uncertain without genetic molecular testing, and would adversely impact the care and management of the patient being tested.



We recently pulled a report to determine how often we received charges for the above codes and found a large number submitted. The term "BY REPORT" means that the claim will be referred to our Medical Review staff and they will be requesting medical records to review the physical exam notes, pre-test counseling, diagnostic studies, etc. These requests will be directed to the hospital; however, typically the information would be maintained in the referring physician's records. Physicians were notified of this contract exclusion in May of 2003 and they are aware of the limitations of coverage for these tests. We recommend that hospitals review their records to determine how often such testing is done and consider what process will be followed to assure that reimbursement is obtained by either the payor or the insured. It would also be wise to determine what physicians are referring these services and work with them to develop processes when referring tests to your facility.



## ACCIDENT CLAIMS

Some, but not all Blue Cross and Blue Shield of Kansas member contracts include a specific benefit which allows payment at 100% of the claim allowance for services related to an accidental injury.

In order for your claim to be processed quickly and efficiently, our claims processing system will look at four form indicators on the claim to explain the date and nature of the accidental injury.

### **Form Locators NECESSARY for accidental injury claims:**

1. Form locator 31-34 – Occurrence Code – Use 01-06 & Date
2. Form locator 66 – Accident Diagnosis Code – If the accident diagnosis is not in the primary position and you have the other three indicators, the accident diagnosis must be in the second or third position for the claim to process under the member's accident benefit. Not all ICD-9-CM diagnosis codes (800-900 range) are considered to be 'accident codes'. Below is a list of diagnosis codes BCBSKS considers to be accident related.
3. Form locator 72 – Accident External Cause (E) Code – Not all E-codes are considered to be 'accident' codes. Look at the code description to determine if the E-code describes an injury or accident. Always make sure the 'accident' E-code is coded before any other E-codes.
4. Form locator 80 – Remarks – Remarks/comments that indicate the nature of the accident. Be sure the remarks specifically indicate the **details** of the accident.

The newsletter of May 26, 2009 has complete information regarding accident claims.

[http://www.bcbsks.com/CustomerService/Providers/Publications/institutional/newsletters/2009/052609\\_AccClaim.htm](http://www.bcbsks.com/CustomerService/Providers/Publications/institutional/newsletters/2009/052609_AccClaim.htm)



## **ACCIDENT DIAGNOSIS CODES:**

### **Local and BlueCard**

V540.1 – V540.9

V71.3 – V71.6

692.76, 692.77

**370.24, 710 – 739.9 (Excludes Diagnosis Codes 733.00, 733.01 and 719.98). Diagnosis 370.24, 710 – 739.9 will process as an accident only when there is other accident information on the claim (i.e. accident occurrence code).**

800 – 989.9

992.3, 992.4, 992.5

994.0 – 994.8

995.81

996.9 – 996.99

### **FEP**

**(The FEP diagnosis listing is very limited and we MUST process claims according to their guidelines.)**

V715

692.76, 692.77

800 – 897.7

900 – 999.9



## MISCELLANEOUS BLUE CARD ISSUES

- Check with Home Plan prior to do any interventional or diagnostic radiological services for precertification requirements. 1-800-676-BLUE (2583)
- Check with Home Plan to determine if outpatient procedures need pre-certifications. 1-800-676 BLUE (2583)
- Remember that when appealing a denial, it must be sent to the Home Plan. Typically, the denial will be the patient's responsibility so providers cannot appeal the denial. However, your assistance will be needed by the insured and they will be required to give you authorization to act on their behalf by signing the following form. This form can be found on our website under FORMS. [http://www.bcbsks.com/CustomerService/Forms/pdf/29-58\\_AuthforRep.pdf](http://www.bcbsks.com/CustomerService/Forms/pdf/29-58_AuthforRep.pdf)

### Authorization of Representative

For purposes of pre- or post-service claim appeal



I, \_\_\_\_\_, authorize \_\_\_\_\_ to act on my behalf to pursue the following appeal of an adverse benefit determination:

**Section 1**  
 Date of Service \_\_\_\_\_ or Pre-Service \_\_\_\_\_  
 Type of Service \_\_\_\_\_  
 Provider \_\_\_\_\_  
 This authorization is limited to the appeal of the designated claim.

**Section 2**  
**Member Information:**  
 Name Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Address Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Telephone No. (Area Code) \_\_\_\_\_  
 Fax No. (Area Code) \_\_\_\_\_  
 ID No. \_\_\_\_\_

**Section 3**  
**Authorized Representative Information:**  
 Name Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Address Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Telephone No. (Area Code) \_\_\_\_\_  
 Fax No. (Area Code) \_\_\_\_\_  
 Provider No. (if applicable) \_\_\_\_\_

Member Signature \_\_\_\_\_ Date \_\_\_\_\_



## **HIPAA 5010**

### **History - Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

- Purpose:
  - Provide greater access to health care insurance (portability)
  - Protect health care data (privacy and security)
  - Promote more standardization and efficiency (transactions, code sets and identifiers)
- Required covered entities who exchange information electronically to do so in a standard format
- Covered entity includes:
  - Health Plan
  - Health Care Clearinghouses
  - Health Care Provider – any provider of medical or other health services, or supplies, who transmits health information electronically

### **What is in the final rule?**

- Covered entities must move to version 5010 for the existing transactions required under HIPAA
  - Professional Claims– 837P
  - Institutional Claims– 837I
  - Dental Claims– 837D
  - Remittance Advices– 835
  - Request for Review and Response - 278
  - Claim Status Inquiry and Response – 276/277
  - Eligibility Inquiry and Response – 270/271
  - Payroll Deducted and other Group Premium Payments for Insurance Products - 820
  - Benefit enrollment and maintenance – 834



### Why change? Current version of the transactions were:

- Published more than 7 years ago and implemented more than 5 years ago
- Doesn't meet current business needs
  - Ex. NPI
- Ambiguous Language
  - Ex. Should vs. Must

### What are the changes?

- Field length changes
- Data added and deleted
  - Includes new or deleted loops, segments or data elements
  - Ex. Some Coordination of Benefits (COB) information deleted
  - Ex. Added fields for ambulance pick-up or drop-off information
- Code values eliminated or added
  - Ex. Remittance advice (835) – The claim adjustment group code of CR (Corrections and Reversals) is eliminated
- New business functionality
  - Ex. Eligibility (270/271) 45 new service types available to report benefit information
  - Ex. Remittance advice (835) Ability to return healthcare policy information

### Timelines

- December 2010 – Covered entities achieve Level 1 Compliance
  - Level 1 Compliance – covered entities have completed internal testing and can send and receive compliant transaction.
- January 2011 – Begin Level 2 testing period
  - Level 2 testing – Trading Partners can begin testing. Trading Partners may move to production with payer approval.
- January 2012 – Achieve Level 2 Compliance
  - **Everyone in production with 5010**



## HIPAA Resources

These offsite links may be helpful as you gather information about HIPAA.

- [U.S. Department of Health and Human Services Administrative Simplification Page](#) - Source for Final Rules, HIPAA FAQs and links to other HIPAA-related sites
- [HIPAA Transaction Implementation Guides from the Washington Publishing Company](#)
- [Web site for Workgroup for Electronic Data Interchange](#) - Provides information and advisory papers regarding HIPAA
- [HIPA Alert](#) - Provides free monthly subscription providing up-to-date e-mail notification of HIPAA information
- [CMS](#) - (Centers for Medicare & Medicaid Services) Advisory body to HHS and the source of legal updates
- [CMS site with links to other Web sites regarding Administrative Simplification](#)

## HIPAA FAQ

Q1. What is the purpose of the Health Insurance Portability and Accountability Act of (HIPAA) of 1996?

- Provide greater access to health care insurance (portability)
- Protect health care data
- Privacy and Security
- Standardization of Transactions, Code Sets, and Identifiers

Q2. Who is a covered entity?

- Health Plan
- Health Care Clearinghouse
- Health Care Provider – any provider of medical or other health services, or supplies, who transmits health information electronically.



Q3. Why is it important to change to HIPAA Version 5010?

- The current HIPAA Version 4010/4010A1 does not meet upcoming business needs
- To support use of ICD-10
- Technical and Data content improvements

Q4. What are standard electronic transactions?

- Professional Claims - 837P
- Institutional Claims - 837I
- Dental Claims - 837D
- Remittance Advice - 835
- Request for Review and Response - 278
- Claim Status Inquiry and Response – 276/277
- Eligibility Inquiry and Response – 270/271
- Payroll Deducted and other Group Premium Payments for Insurance Products - 820
- Benefit enrollment and maintenance - 834

Q5. What are some of the updates with HIPAA Version 5010?

- Some field length changes
- Data is added and deleted
- Includes new or deleted loops, segments or data elements. A couple examples of this would be:
  - Some Coordination of Benefits (COB) information deleted
  - Added fields for ambulance pick-up or drop-off information
- Code values eliminated or added. Example: Remittance advice (835) – The claim adjustment group code of CR (Corrections and Reversals) is eliminated
- New Business functionality. Example: Eligibility (270/271)
- Ability to return healthcare policy information on the 835



Q6. Who within your organization needs education on HIPAA Version 5010?

- Virtually everyone
  - Information technology health information management
  - Quality utilization management
  - Claims, billing, auditing, accounting, financial management, corporate compliance and clinicians.

Q7. Does HIPAA Version 5010 affect all providers, regardless of contracting status?

- Yes. HIPAA Version 5010 affects any covered entity utilizing electronic transactions.

Q8. Dates to Remember:

- December 2010 – Covered entities achieve Level 1 Compliance.
  - This means payers must have completed internal testing and can send and receive compliant transactions.
- January 2011 – Begin Level 2 testing period
  - This means Trading Partners (TPs) can begin testing. We will move TP to production once testing is complete.
- January 2012 – Achieve Level 2 Compliance.
  - This means everyone must be in production with HIPAA Version 5010.

Q9. What should I do?

- Contact your vendor. Ask, what are your plans?
- If you are using a Clearinghouse contact them. Ask, what are your plans?
- Educate yourself. Attend workshops and sign up for email list:
  - [www.ask-edi.com](http://www.ask-edi.com) and [www.bcbsks.com](http://www.bcbsks.com)

## REMINDERS

- **TURN OFF PAPER REMITTANCE ADVICES**  
**BCBSKS is encouraging providers to rely on the Web based remittance advice (RA) process to receive their payment information. What are the advantages to “shutting off” the paper RA?**

Some of the advantages of Web based RAs are:

- Search function (patient name, ID, account number, etc.)
- Enlarge the print size
- Quickly locate information (scrolling)
- Receive the RA quicker
- Eliminates paper (you can still print a copy if needed, and
- Saves space – save the RA to your system or to a CD.

**NOTE: If you have multiple provider numbers, please “shut off” the paper RA for each number.**

- **ELECTRONIC SECONDARY CLAIMS**  
Blue Cross and Blue Shield of Kansas guidelines for electronic secondary claims are as follows:
  - If Medicare is primary, we will not accept electronic secondary claims at this time.
  - All other secondary submissions will be accepted electronically. If you are NOT submitting secondary claims in this manner, please attempt to implement this process immediately and if you have problems, contact your provider representative.

- **ABSTRACTS**  
SECTION IV: REQUESTS FOR INFORMATION

**Abstract Information:**

Severity/Intensity elements, Hospital Code Number, Medical Record Number, Patient's Account Number, Abstract Record Counter, Admission Class, Admission Hour, Admission Date, Principal Procedure Date, Discharge Date, Birth Date, Gender, Race, Point of



Origin, Primary Payment Status, Discharge Hour, Transfer Destination, Special Units, Primary Service, Attending Physician's Number, Principal Surgeon's Number, Other Physician or Surgeon's Number, Accommodation on Admission and Discharge, Member ID Number, Primary Diagnosis, Admitting Diagnosis, up to 24 Secondary Diagnoses, Present on Admission (POA) Indicator, Diagnosis Dates, Principal Procedure, up to 24 Secondary Procedures with Surgeons and Dates, Zip Code, Patient Last Name, Patient First Name, Social Security, Number, Patient Status, Batch Year, Batch Month, Batch Number, Hemoglobin Low, and Hemoglobin Drop.

**Abstract information is to be transmitted to BCBSKS as needed or on a monthly basis (45 days from the end of each month) on files meeting the above specifications. Failure to submit medical abstract information within the time frame specified above shall result in the Contracting Provider being placed on prepayment utilization review.**

This mechanism consists of a review for medical necessity of all inpatient services and is based on medical record information, which will be requested from the Contracting Provider. Final determination of the MS-DRG is based on the abstract.

Severity/Intensity elements are those clinical data elements deemed necessary to augment the utilization review process. Severity/Intensity elements may change from time to time and will be collected in 36 one-digit abstract fields and transmitted as part of the abstract file.

Additional file layout specifications are available for those hospitals requiring such information for their particular abstracting service at <http://www.bcbsks.com/khds/>.



## • Institutional Provider e-News Sign-up

Please complete the form below with your contact information, then choose from the list what mailing lists you would like to sign-up for:

All fields are required unless noted

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<b>Facility / Organization name:</b>	<input type="text"/>
<b>City, State:</b>	<input type="text"/>
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- FAQs
- Latest News
- Medical Review
- National Provider Identifier (NPI)

### Manuals

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- End Stage Renal Disease Facility
- Home Health Agency
- Hospice
- Hospital
- Miscellaneous
- Substance Abuse Facilities



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- Substance Abuse Facilities

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- Hospice
- Hospital
- Substance Abuse Facilities

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You will not receive updates if it is incorrect.**

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- **NEW REVENUE CODE MANUAL (Published March 09)**  
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<http://www.bcbsks.com/CustomerService/Providers/Publications/institutional/manuals/index.htm>
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## TRICARE

- **OPPS**

OPPS payment methodology became effective for TRICARE on May 1, 2009.

**Information can be found in the....**

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

**CHAPTER 13, SECTION 1 GENERAL 14**

Implementing instructions within [Chapter 13, Section 1](#) through [5](#):

OPPS Data Elements Available on TMA's web site.

The following data elements are available on TMA's OPPS web site at <http://www.tricare.mil/opps>

1. APCs with SIs and Payment Rates.
2. Payment SI by HCPCS Code.
3. Payment SIs/Descriptions.
4. CPT Codes That Are Paid Only as Inpatient Procedures.
5. Statewide Cost-to-Charge Ratios (CCRs).
6. OPPS Provider File with Wage Indexes for Urban and Rural Areas, uses same wage indexes as TRICARE's DRG-based payment system, except effective date is January 1 of each year for OPPS.
7. Zip to Wage Index Crosswalk.

- **BEHAVIORAL TELEHEALTH PROGRAM**

**TRICARE Offering Telehealth Program - ATTN: Behavioral Health Prescribing Providers**

Effective August 1, 2009, TriWest Healthcare Alliance will be implementing the new TriWest Online Care program, a program to increase behavioral health service for TRICARE active duty service members (ADSMs) and active duty family members (ADFMs) via telehealth services.

Providers can participate in this exciting opportunity as an Originating Site Facility or a Distant Site Facility. An Originating Site is the site where an eligible TRICARE beneficiary is located when the service is being furnished via a videoconferencing system. A Distant Site is the location where a TRICARE provider will render services being furnished via a



videoconferencing system. TRICARE will reimburse for both types of services.

One of the areas in which we need to augment existing access to providers is in the area of behavioral health prescribers. Our TRICARE beneficiaries, particularly those located in rural areas, would benefit from additional access to those distant providers who can prescribe medications to behavioral health patients. Only network providers located in the West Region are currently eligible to participate in the demonstration project with TriWest.

TriWest sent an e-mail survey on June 10 to providers with information in order to gauge interest in participating in the program. If you are interested in providing additional care options for your TRICARE beneficiaries by offering space in your office for beneficiaries to access these services or by becoming a TRICARE Distant Site Behavioral Health Care provider, please click this [link](#) and complete the short questionnaire identifying your potential interest. The [local network representative](#) will follow-up with those providers indicating an interest. If you already have responded to the survey and have been contacted by your local network representative, there is no need to take the survey again. **If you are interested in participating, please respond to the survey by Friday, June 26.**

Here are the links to information regarding [distant sites](#) and [originating sites](#). For more information regarding TRICARE Telemedicine policies, please refer to the TRICARE Policy Manual, Chapter 7, Section 22.1, at [www.tricare.mil](http://www.tricare.mil).

• **SEMINARS**

**Provider Seminar Registration**

Seminar Search

Type:

State:

Location	Address	Session	Website	Map
<a href="#">Holiday Inn Select</a>	549 S. Rock Rd. Wichita, KS 67207	10/1/2009 9:00 AM-11:30 AM <b>56 Seat(s) Remaining</b>	<a href="#">Website</a>	<a href="#">Map</a>
<a href="#">DoubleTree Hotel Overland Park</a>	10100 College Blvd. Overland Park, KS 66210	10/6/2009 9:00 AM-11:30 AM <b>56 Seat(s) Remaining</b>	<a href="#">Website</a>	<a href="#">Map</a>
<a href="#">Capitol Plaza Hotel</a>	1717 SW Topeka Blvd. Topeka, KS 66612	10/7/2009 9:00 AM-11:30 AM <b>17 Seat(s) Remaining</b>	<a href="#">Website</a>	<a href="#">Map</a>
<a href="#">Riverfront Community Center</a>	123 S. Esplanade Leavenworth, KS 66048	10/13/2009 9:00 AM-11:30 AM <b>47 Seat(s) Remaining</b>	<a href="#">Website</a>	<a href="#">Map</a>
<a href="#">Country Inn &amp; Suites</a>	2760 S. 9th St. Salina, KS 67401	11/3/2009 9:00 AM-11:30 AM <b>25 Seat(s) Remaining</b>	<a href="#">Website</a>	<a href="#">Map</a>
<a href="#">Geary Community Hospital</a>	1110 St. Mary's Rd. Junction City, KS 66441	11/4/2009 9:00 AM-11:30 AM <b>40 Seat(s) Remaining</b>	<a href="#">Website</a>	<a href="#">Map</a>
<a href="#">Clarion Hotel-Manhattan</a>	530 Richards Dr. Manhattan, KS 66502	11/10/2009 9:00 AM-11:30 AM <b>73 Seat(s) Remaining</b>	<a href="#">Website</a>	<a href="#">Map</a>



## Provider Seminar Registration

Seminar Search

Type:

State:

Location	Address	Session	Website	Map
<a href="#">Holiday Inn Select</a>	549 S. Rock Rd. Wichita, KS 67207	10/1/2009 1:30 PM-4:00 PM <b>131 Seat(s) Remaining</b>	<a href="#">Website</a>	<a href="#">Map</a>
<a href="#">DoubleTree Hotel Overland Park</a>	10100 College Blvd. Overland Park, KS 66210	10/6/2009 1:30 PM-4:00 PM <b>75 Seat(s) Remaining</b>	<a href="#">Website</a>	<a href="#">Map</a>
<a href="#">Clarion Hotel-Manhattan</a>	530 Richards Dr. Manhattan, KS 66502	11/10/2009 1:30 PM-4:00 PM <b>69 Seat(s) Remaining</b>	<a href="#">Website</a>	<a href="#">Map</a>

- **eSEMINARS**

### TRICARE Provider eSeminar

Thank you for your interest in taking a TRICARE Provider eSeminar. TriWest Healthcare Alliance developed these online seminars with busy providers and their staff in mind. TRICARE Provider eSeminars allow providers and their staff to learn about TRICARE and TriWest in the comfort of their own office, home or any location with Internet access. In addition, the eSeminars are a good way to educate new staff about TRICARE and for experienced staff to get a refresher on specific topics or areas of interest.

To take an eSeminar, you will need headphones or speakers on your computer. It is important to complete the online form at the end of the eSeminar in order to allow us to track your “attendance.” You will need your Tax Identification Number(s) (TIN) to complete the online form. If you can’t complete the eSeminar in one setting, you can pause it and finish it later.



eSeminars are currently available on the following topics:

- Outpatient Prospective Payment System (OPPS) (posted 4/1/09) – approximately 18 minutes
- TRICARE 101 (posted 4/1/09) – approximately 40 minutes
- Medical/Surgical (posted Spring 2009) – approximately 83 minutes
- Behavioral Health (posted Spring 2009) – approximately 75 minutes
- Extended Health Care Option (ECHO) – approximately 30 minutes
- Home Health Agency Prospective Payment System – approximately 30 minutes
- TRICARE's Hospice Benefit (posted 5/20/09) – approximately 25 minutes long

The TRICARE 101 eSeminar is a good option for provider office staff new to TRICARE or when an overview of the TRICARE Program and TriWest processes is sufficient. Those who need a more thorough understanding of the TRICARE program and benefits, the referral and authorization process, and claims submission should take either the Medical/Surgical eSeminar or the Behavioral Health eSeminar, depending on your specialty.

The Medical/Surgical and Behavioral Health eSeminars cover the following topics:

- TRICARE Overview
- TRICARE Programs and Benefits
- Clinical Programs
- Referrals and Authorizations
- Consult and Treatment Reports
- Claims and Reimbursement
- Electronic Data Interchange (EDI)
- Provider Resources

eSeminars Coming Soon:

- Updated ECHO
- Updated EDI
- Updated Home Health Agency Prospective Payment System

You may begin an eSeminar immediately. No pre-registration is required and there is no waiting. Just click on the “Begin the Seminar” button below and you can choose the eSeminar that you wish to take. At the completion of the eSeminar,



take the time to follow the additional instructions to receive credit for taking the course.

After completing a course, if you would like Medical/Surgical or Behavioral Health educational materials to be mailed to you, just request them when completing the online form.

If you have any questions about eSeminar content, you may e-mail us at [providerservices@triwest.com](mailto:providerservices@triwest.com). If you have technical difficulties with accessing the eSeminars, you may e-mail us at [pseminar@triwest.com](mailto:pseminar@triwest.com).

- **HIGH VOLUME PROVIDER VISITS**

TriWest provides us with a list of providers that are considered High Volume. This would include those providers that have either a high utilization of services or high dollar rate. In an effort to assure that educational needs are met, we must have a face to face meeting through a provider visit, a round table discussion or a provider must attend a TriWest seminar. Your provider representative will be contacting you if your facility is listed on this report.



## HEALTHCARE COSTS/REFORM

Following are a couple of excerpts from Angie Strecker, Manager of Provider Relations and Blue Cross and Blue Shield of Kansas CEO, regarding healthcare costs and reform.

### **From Angie Strecker's letter of July 24, 2009:**

*The past year has been intriguing on both the political and financial fronts. On the political scene, we are all watching President Obama's Health Care Reform proposal unfold and we speculate on what the changes will mean for patient choice, health care accessibility and, of course, provider reimbursement.*

*Financially, many businesses, including health care providers, are struggling with difficult decisions which include reexamining investment decisions, modifying capital improvement plans and even reducing staff. Many of these decisions impact the health insurance of individuals and families. This was a topic of discussion at the BCBSKS Hospital Forums and, because we had a record attendance at the meetings this year, we know that the leaders in our Kansas hospitals are well aware of this fact.*

*Blue Cross and Blue Shield of Kansas has also been impacted by the recent economical shift and we fully understand the necessity of conservative fiscal decisions. I am happy to say that BCBSKS continues to spend only about 8 cents of every health care dollar on administrative expenses. This is far lower than the figures reported in the media regarding insurers as a whole, yet we continue to strive to provide superior service to both our customers and providers. This reveals that the greater share of the insurance premium lies with the price and use of medical services.*

### **From Andy Corbin:**

*The Association's efforts are focused on the following four key messages:*

- 1. Blue Cross and Blue Shield Plans have taken a leadership role in developing and bringing to the table solutions to bring costs under control, expand coverage to everyone and improve the quality and safety of care. We support the broad framework of the reform proposals being advocated by the President and members of Congress.*
- 2. We have long supported major changes to our own industry to assure all individuals have access to insurance regardless of pre-existing conditions and individuals do not pay more simply because they are sick. For these insurance reforms to work, they must be accompanied by comprehensive reform that assures everyone is covered otherwise young and healthy people could wait until they are sick to purchase coverage – raising costs for everyone. There also must be subsidies to make sure coverage is affordable.*
- 3. But insurance reforms – while important – are only a part of the solution. For health care reform to be sustainable and address rising costs for everyone, it must include major delivery system reforms to change current incentives to promote the best possible care, instead of more services. This includes adopting new Medicare payment models to reward quality, promoting evidence-based care and implementing programs that promote value-based purchasing.*



4. Lastly, we believe a government-run plan runs counter to the goals of reform and would result in millions of people losing the current private coverage they like.

Andy says the company also is taking steps to prepare for the future as a follow-up to our strategic planning process. A cross-divisional leadership team will soon begin meeting to identify and plan for various scenarios. This activity will help the company know which direction it needs to move depending on what type of reform bill is eventually signed into law. “No matter what legislation passes, we can expect there to be some changes in our industry,” he says. “I am committed to assuring that Blue Cross and Blue Shield of Kansas is ready to meet those

The following information was recently published on the Blue Cross Association website:

**Government-Run Health Plan: What It Means for Providers  
June 2009**

**Issue:** Some policymakers support a new government-run health insurance plan to compete with private health plans for the non-Medicare population. In the House, the government plan would pay healthcare providers based on Medicare rates (or Medicare +5% for certain physicians and other professionals). Senate proposals are still under development, but are likely to include a government plan. Comprehensive reform should build on today’s employer-based system to extend coverage to everyone, rein-in costs, and improve quality. Creating a government plan is unnecessary and would be very problematic.

**Key Points**

- **Most Americans will lose their private health insurance under proposals to create a government plan.**
  - A recent analysis by The Lewin Group of the House bill estimates that 114 million people would be shifted into the government plan within three years of it becoming operational.
  - Despite the fact that most Americans are satisfied with their own health insurance today, the proposal could shift two-thirds of the population into the new government plan.
  
- **Healthcare providers will face significant reductions in revenue that would threaten improvements in the healthcare delivery system.**
  - Proposals would achieve savings by paying providers at Medicare rates, which average 30 percent less than private rates for hospitals and 20 percent less for physicians.
  - Shifting up to 114 million privately insured patients into a government-run plan would substantially reduce patient revenue. According to Lewin’s analysis of the House bill, when a government plan is fully operational:
    - Physician net income would decline by \$12 billion annually – a loss of \$36,000 in net revenue per physician compared to reform without a government plan.
    - Hospital margins would decline by 63% – a \$31.3 billion annual loss.



- Private investments and partnerships currently underway to improve the delivery system would be compromised. A government plan would be less innovative than the private sector and undermine efforts to improve our delivery system (e.g., it took Medicare 30 years to cover preventive care and 40 years to cover outpatient drugs).
- **The Government Plan will use its built-in advantages – no matter how it is originally structured – to eventually take over the market.**
  - Even if the government plan initially reimburses providers up to 5 percent more than Medicare – which is still 15-25 percent lower than what private insurers pay – budgetary pressures will force the government to ratchet down rates, resulting in longer waits and reduced access to care for those who cannot afford to maintain private insurance.
  - Medicare was originally set up to pay providers at rates that were comparable to private insurance plans, but quickly devolved into price setting to control federal budget outlays.
- **A government plan is not necessary under health care reform.** Rather than creating a new government plan, comprehensive reform should build on today's employer-based system to extend coverage to everyone, rein-in costs, and improve quality.