HEALTH DEPARTMENT BILLING GUIDELINES

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GENERAL INFORMATION

Blue Cross and Blue Shield of Kansas (BCBSKS) members are encouraged to seek professional services from contracting providers. The most significant value to you as a contracting provider is direct payment from BCBSKS, which minimizes your collection efforts and increases cash flow. Other contracting benefits include detailed claims payment information, access to educational workshops at no charge, access to our Provider Network Services for claim coding questions and access to our website (www.bcbsks.com). Information available through our website includes member eligibility, claims status, referrals, remittance advice and precertification, policy memos and newsletters.

BCBSKS accepts claims in electronic format and on the CMS-1500 form (Version 02-12).

WHAT IS EDI?

Electronic Data Interchange (EDI) is the computer-to-computer transmission of business data in a standard format, which replaces traditional paper business documents. Health care providers generally create EDI transactions by utilizing practice management software. A claim file is generated and transmitted to its destination via URL.

Free claims filing software – PC-ACE Pro 32 is a Windows - based claims management system that is ideally suited for a one-person office or a networked billing staff. The current version will allow key entry, import of NSF 3.01, print image, ANSI and Proprietary formats for primary and secondary claims.

Key features of the software include:

- Self-Installing
- Self-Training via the online help system
- Comprehensive real time desktop editing provides immediate user feedback
- Combined Professional and Institutional all-payor system
- Electronic submission of claims in ANSI 837 formats; Automatic code validation (diagnosis, procedure, etc.)

More than 90 percent of claims are submitted electronically. For more information, call (800) 472-6481 or (785) 291-4178, email askedi@ ask-edi.com, or visit ask-edi.com.
DOCUMENTATION GUIDELINES

The importance of having the services performed sufficiently documented cannot be overemphasized.

An appropriately documented medical record will reduce claims processing problems and support the care provided. In order to correctly code services for reimbursement purposes the medical record documentation should be completed prior to filing the claims.

Additional information that is not part of the medical record will not be accepted — only records created contemporaneous with the treatment will be considered pertinent.

Medical records are expected to contain all the elements required in order to file the claim and substantiate the claim.

Letters and checklists are not acceptable as documentation and do not replace what should be in the medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be understandable to a reviewer.

Additional information on documentation, please refer to Policy Memo No. 1 XI Documentation.

HOW TO READ MEMBER ID CARDS

For more information on how to read Member ID Cards, see pages 4-1 and 4-2 of the Professional Provider Manual.
BILLING AND CODING GUIDELINES

For reporting medical services the American Medical Association (AMA) publishes a list of procedure codes and nomenclature on an annual basis. This publication is known as current procedural terminology (CPT®) and is considered the first level of the Health Care Financing Administration Common Procedural Coding System (HCPCS). BCBSKS also will accept the AMA CPT® codes as the first level of coding.

The most common AMA CPT® codes utilized by health departments are the “Evaluation and Management” procedure codes also known as “E & M” codes. These codes are for reporting office calls.

It is important to have adequate documentation to support each AMA CPT® and HCPCS code submitted for reimbursement. For BCBSKS, medical documentation should include the following:

- Medical necessity of services rendered
- Evidence that all services were performed
- Support level of service billed
- Support duration of care
- Support frequency of care

Refunds could be requested if records don’t support the above items.

Documentation should include, but is not limited to, the following when applicable:

- Reason for the visit/encounter Chief complaint in the patient’s own words
  - Review of systems, personal and/or family history
- The scope of the examination
- Positive and pertinent negative exam findings
- Diagnosis or impression
- Treatment details and future treatment recommendations
- Medication names and dosage administered, prescribed or refilled
- Copies of oral and/or written instructions to the patient
- The recommended follow-up date
- Findings and results of any pathology, clinical laboratory, and radiology examinations.
- Contacts with the patient, as well as others providing care to the patient
- Informed consent
- Diagnosis and prognosis

In addition, there are guidelines for documentation:

- All written documentation must be legible.
• Use ink, preferably black ink, for ease of reading and photocopying purposes.
• Use only abbreviations or symbols that are universal and commonly accepted within the specialty.
• All entries should be dated and signed or initialed.
• Never alter, destroy, rewrite or replace a prior medical record. Corrections should be made by lining through the entry and entering the new information with the date when the new information was added.
• Additional information that is not part of the medical record will not be accepted; that is, only records created at the time and part of the original record with treatment will be considered pertinent.
• Do not leave blank spaces or skip lines for the purpose of later entries.
• Use objective rather than subjective language. State medical facts, not conclusions.
• Include identification of the performing provider, even in solo practices.

Blue Shield accepts “Subjective, Objective, Assessment, Plan” notes commonly known as SOAP notes. Any other method that includes all this information would be acceptable.

This information includes:

• **Subjective Complaint** – The patient’s reason for seeking care, how he/she feels, what happened, in the patient's own words.
• **Objective Findings** – Results of the physical exam including documentation of the patient’s progress, tests, and/or x-rays.
• **Assessment** – The provider’s evaluation of the patient’s condition.
• **Plan** – The initial visit would include the overall diagnostic and/or treatment plan. Follow-up visits would show any appropriate changes in the diagnosis and/or treatment plan and why.

BCBSKS guidelines indicate a medical record should be kept for seven years unless there are reasons to keep it longer.

**Evaluation and Management Codes**

In a health department environment, a limited range of E & M codes would be submitted including 99201, 99202, 99203, 99211, 99212 and 99213. These codes are used for new patients (99201, 99202, 99203) and established patients (99211, 99212, 99213) when treated in an office and/or outpatient setting.

There also are preventive medicine codes that may be used to report the preventive medical evaluation of infants, children and adults. These visits will not have a presenting problem as they are "well" preventive visits. These codes are defined as a new or established patient and by age. **Health Care Reform Preventive Health Benefits with Recommended CPT and Diagnosis Codes**
The codes for new patients are 99381-99387 and for established patients 99391-99397. If the age of the patient does not match the age described in the code, the claim will be rejected.

According to AMA CPT® and BCBSKS definitions, a new patient is a patient who hasn’t been seen for three or more years in a practice. An established patient is a patient who has been treated in the practice within the past three years.

When a patient makes an appointment, a reason for the encounter needs to be established. Per AMA CPT®, a “concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient’s words.”

At this point a diagnosis is established for the encounter. The reason for the encounter will be assigned an ICD-10 code to correlate with the AMA CPT® code. An ICD-10 code defines what prompted the encounter and the AMA CPT® code defines what service was performed during the encounter.

The different levels of office visits are determined by the following components:

- History
- Review of systems, personal and/or family history
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time *

*In a health department setting, time probably would not be a factor in determining the level of E & M code.

However, the first four components – history, review of systems, examination, medical decision making – are key components to selecting the level of E & M code.

The extent of the history is determined by the clinical opinion of the performing provider based on the patient’s complaints. The levels of history most likely to be seen in a health department setting are problem focused or expanded problem focused.

Per AMA CPT® guidelines they are defined as follows:

- **Problem focused**: chief complaint; brief history of present illness or problem.
- **Expanded problem focused**: chief complaint; brief history of present illness; problem pertinent system review.
• **Detailed**: chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history directly related to the patient’s problems.

The next step is to decide on the appropriate examination level. Once again, this is determined by the performing provider. The level of examinations which would be expected to be seen in a health department setting is as follows per CPT® guidelines:

- **Problem focused**: a limited examination of the affected body area or organ system.
- **Expanded problem focused**: a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- **Detailed**: an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

The third key component is to determine the complexity of the medical decision making as determined by the performing provider. In a health department setting the two levels of medical decision making that would routinely be seen are straightforward and low complexity.

- **Straightforward**: minimal number of diagnoses or management options; minimal or no amount and/or complexity of data to be reviewed; minimal risk of complications and/or morbidity or mortality would be involved.
- **Low complexity**: limited number of diagnoses or management options; limited amount and/or complexity of data to be reviewed; low risk of complications and/or morbidity or mortality would be involved.

After selecting the level of office visit that is to be submitted for reimbursement, it needs to be determined what additional services, if any, were provided to the patient, i.e., injections and or immunizations.

The CMS HCPCS code list would be used to locate drugs to supplement the AMA CPT® codes as the second level of the coding system.

After selecting the level of office visit to be submitted, and if applicable, a second level (HCPCS) code; a diagnosis code must be assigned. Per AMA CPT® guidelines, the primary diagnosis is what prompted the encounter as described in the patient's own words.

Per the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) guidelines, the primary diagnosis is what prompted the encounter as described in the patient's own words.
ICD-10-CM Coding:
Codes are three-to-seven digits long. The first digit will use alpha. The second digit will use numeric. Digits three through seven are alpha or numeric. It is important to learn the guidelines located in the front of the ICD-10 book.

Examples:
- And + And/Or
- Excludes 1 – Means NOT CODED HERE
- Excludes 2 – Means NOT INCLUDED HERE
- Code most Acute DX first
- “-“ at the end of code means the Tabular contains multiple code options
- “With” sequenced immediately following main term, not in alphabetic order
- Brackets show manifestation codes and abbreviations:
  - Example 1: Anemia
    - Hookworm Disease B76.9 [D63.8]
  - Example 2: Abnormal
    - Electrocardiogram [ECG] [EKG] R94.31

ICD-10 codes can be up to seven digits. This example shows an ICD-10-CM code for Foreign body, right ear and the code placement.

T16.1XXA
  T16 – Foreign body in ear
  .1 – Right Ear
  XX – place holder
  A – Initial Encounter

Other Examples:
- Prophylactic Vaccination for any routine childhood examination
  - Z23
- Encounter for General Adult Medical Examination without Abnormal findings
  - Z00.00
- Allergic Rhinitis due to animal (cat) (dog) hair and dander
  - J30.81
- Encounter for Pregnancy Test, result positive
  - Z32.01
- Vaginitis & Vulvovaginites Unspecified
  - N76.0 Acute Vaginitis
  - N76.1 Subacute and Chronic Vaginitis
  - N76.2 Acute Vulvitis
  - N76.3 Subacute and Chronic Vulvitis
- Contact with and (suspected) exposure to Lead
  - Z77.011
- Encounter for screening for Malignant Neoplasm of Prostrate
  - Z12.5
- Contact with and (suspected) exposure to Meningococcus
  - Z20.811
ADMINISTRATION AND IMMUNIZATION REIMBURSEMENT

BCBSKS provides coverage for medically necessary services including routine childhood immunizations up to age six under all fully insured contracts. Self-funded groups also have the option of providing coverage for routine childhood immunizations.

The Medicine Section includes immunization administration and immunization codes.

NOTE: There are numerous code revisions in this section for 2016. Please review.

AMA CPT® codes 90460-90474 represent codes for immunization administration for Vaccines/Toxoids.

90460, Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component, for BCBSKS, should be billed for the initial administration ("injection").

+90461, each additional vaccine/toxoid component, for BCBSKS, should be billed for each additional administration ("injection") administered on the same day as the 90460.

90471, Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid), for BCBSKS, should be billed for the initial administration ("injection").

+90472, each additional vaccine (single or combination vaccine/toxoid), for BCBSKS, should be billed for each additional administration ("injection") administered on the same day as the 90471.

$21.48 for the initial injection (90460). Unit limitation 1
$15.08 for each additional injection (90461) administered on the same the same day. Unit limitation 3
$16.52 for the initial injection (90471). Unit limitation 1
$13.92 for each additional injection (90472) administered on the same day. Unit limitation 3
$13.31 for administration by intranasal or oral route (90473). Unit limitation 1.
$13.32 for additional vaccine (90474). Unit limitation 1.

These administration codes should be reported on the same claim in addition to the vaccine/toxoid code(s) 90476-90749.

NOTE: "+" indicates this code is an add-on code to the primary administration code.
COMPLETING A 1500 CLAIM FORM

For help with completing a 1500 claim form, a tutorial is available at bcbsks.com.

BCBSKS PROFESSIONAL RELATIONS REPRESENTATIVES

As a contracting provider with BCBSKS, you receive the services of a professional relations staff dedicated to providing you with easy-to-access information regarding policy memos and claims information. Other services provided include:

- A dedicated field staff available to visit your office to address any operational issues.
- Periodic workshops conducted by professional relations staff who delivers continuous training for new and experienced medical assistant staff to help update them on new administrative procedures to ensure timely claim payments.
- Providers and their staff having access to professional relations hotline personnel to answer policy questions or obtain assistance with claim coding questions.

Provider Network Services, Topeka 800-432-3587 or 785-291-4135.
REFERENCE MATERIALS


ICD-10-CM, Optum 2017