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I. General Information

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 in Topeka is available at 785-291-4135 or 800-432-3587, or prof.relations@bcbsks.com.

Information available through Availity includes member eligibility/benefits and claim status. Remittance advice and member ID lookup can be accessed in the BCBSKS Secure Section (Blue Access) through Availity. Precertification, policy memos, manuals, and newsletters are available in the professional provider section at www.bcbsks.com.

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

II. 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 – ABILITY|PC-ACE 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.
III. How to Read Member ID Cards

Example of ID Card:

- Ask patient for current ID card at each visit.
- Majority of Blue branded ID cards display a three-digit alpha prefix.
  -Exceptions are standalone vision and pharmacy, stand-alone dental program.
  - (FEP) that has a letter “R” in front of the ID#
- Enter the ID# exactly as it appears on the card, including the alpha prefix.
- Logos identify the type of coverage the member has and/or provider’s reimbursement.
IV. Documentation Requirements/Medical Records

CPT code selection should be within the scope of the licensure of the rendering Provider.

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.

A. Form of documentation in medical records – Documentation in the medical record must accurately reflect the health care services rendered to the patient and is an integral part of the reimbursement, audit, and review processes.

1. Documentation of Medical Services – Medical records are expected to contain all the elements required in order to file and substantiate a claim for the services as well as the appropriate level of care, i.e., evaluation and management service (see Policy Memo No. 2). Each diagnosis submitted on the claim must be supported by the documentation in the patient’s medical record. The contracting provider agrees to submit claims only when appropriate documentation supporting said claims is present in the medical record(s) which shall be made available for audit and review at no charge.

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

2. Cloned Medical Record Documentation – BCBSKS expects providers to submit documentation specific to the patient and specific to the individual encounter. Documentation should support the individualized care each BCBSKS member received.

Documentation identified as cloned, copied and pasted, pulled forward, or inserted via template without identifiable and appropriate updates specific to the current visit
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will not be considered for the purposes of determining services provided for that visit.

3. BCBSKS has adopted the following standards for documentation of medical services.

Each patient’s health record shall meet these requirements:

a. Be legible in both readability and content.
b. Contain only those terms and abbreviations that are or should be comprehensible to similar providers/peers.
c. Contain patient-identifying information on each page to ensure pages are not lost or misfiled.
d. Indicate the dates any professional service was provided and date of each entry.
e. Contain pertinent information concerning the patient’s condition and justify the course of treatment. The record must document the medical necessity and appropriateness of each service.
f. Documentation of examination and treatment(s) performed or recommended (why it was done and for how long) and physical area(s) treated, vital signs obtained and tests (lab, x-ray, etc.) performed, and the results of each.
g. List start and stop times or total time for each CPT code/service performed on all timed codes per CPT nomenclature.
h. Document the initial diagnosis and the patient’s initial reason for seeking the provider’s care.
i. Document the patient’s current status and progress during the course of treatment provided.
j. Indicate the medications prescribed, dispensed, or administered, and the quantity and strength of each.
k. Include all patient records received from other health care providers if those records formed the basis for treatment decision by the provider.
l. Each entry shall be authenticated by the person making the entry (see Signature Requirements) unless the entire patient record is maintained in the provider’s own handwriting.
m. Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes, other writings, or recordings once this information is converted to final form; the final form shall accurately reflect the care and services rendered to the patient.
4. **Signature Requirements** – In the content of health records, each entry must be authenticated by the author. Authentication is the process of providing proof of the authorship signifying knowledge, approval, acceptance or obligation of the documentation in the health record, whether maintained in a paper or electronic format accomplished with a handwritten or electronic signature. Individuals providing care for the patient are responsible for documenting the care. The documentation must reflect who performed the service.

   a. The handwritten signature must be legible and contain at least the first initial and full last name along with credentials and date.

   b. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.

   c. An electronic signature is a unique personal identifier such as a unique code, biometric, or password entered by the author of the electronic medical record (EMR) or electronic health record (EHR) via electronic means, and is automatically and permanently attached to the document when created including the author’s first and last name, with credentials, with automatic dating and time stamping of the entry. After the entry is electronically signed, the text-editing feature should not be available for amending documentation. Example of an electronically signed signature: “Electronically signed by John Doe, M.D. on MM/DD/YYYY at XX:XX A.M.”

   d. A digital signature is a digitized version of a handwritten signature on a pen pad and automatically converted to a digital signature that is affixed to the electronic document. The digital signature must be legible and contain the first and last name, credentials, and date.

   e. Rubber stamp signatures are not permissible. This provision does not affect stamped signatures on claims, which remain permissible.

5. **Corrections in the Medical Record** – If the original entry in the medical record is incomplete, contracting providers shall follow the guidelines below for making a correction, addendum, or amendment. Signature requirements as defined above apply to all corrections in the medical record.

   a. **Errors in paper-based records** -- To add an addendum or amendment to paper-based records, draw a single line in ink through the incorrect entry, print the word "error" at the top of the entry, the reason for the change, the correct
information, and authenticate the error by signing (including credentials) the notation with the date and time. Entries should not be antedated (assigned a date earlier than the current date). Errors must never be blocked out or erased.

b. Electronic medical records/Electronic health records:

i. Addendum – An addendum is new documentation used to add information to an original entry that has already been signed. Addenda should be timely with date and time of the addendum. Write “addendum” and state the reason for the addendum referring back to the original entry.

Complete the addendum as soon after the original note as possible. Identify any sources of information used to support the addendum. Entries should not be antedated (assigned a date earlier than the current date).

ii. Amendment – An amendment is documentation meant to clarify or provide additional information within the medical record in conjunction with a previous entry. An amendment is made after the original documentation has been completed and signed by the provider. All amendments should be timely with the date and time of the amended documentation. Write “amendment” and document the clarifying information referring back to the original entry.

Complete the amendment as soon after the original note as possible. Entries should not be antedated (assigned a date earlier than the current date).

6. Use of Medical Scribes – Scribes are not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider. BCBSKS expects the signing and dating of all entries made by a scribe to be identifiable and distinguishable from that of a physician or licensed independent practitioner. All entries made by a scribe are ultimately the practitioner’s responsibility; therefore, review of the documentation and verification of its accuracy, including authentication by the practitioner, is required.
V. Billing and Coding Guidelines

**Evaluation and Management Codes**

CPT code selection should be within the scope of the licensure of the rendering provider.

Services provided by a RN should only be billed with CPT code 99211, regardless of level of E/M service provided.

In a health department environment, a limited range of E & M codes would be submitted including 99202, 99203, 99211, 99212 and 99213. These codes are used for new patients (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, and can be found in the Preventive Services Guide. Preventive Services should only be billed when performed by a MD, DO, PA or APRN.

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:
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- 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 rendering 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 rendering 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 rendering 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, 10th 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
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- 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
    - 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 & Vulvovaginitis, 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 Prostate
  o Z12.5
• Contact with and (suspected) exposure to Meningococcus
  o Z20.811

VI. 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.

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
  $16.83 for administration by intranasal or oral route (90473). Unit limitation 1.
  $13.32 for additional vaccine (90474). Unit limitation 1.
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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.

**VII. Administration of Other Injectables**

Administration of injection (96372) is considered content of service if performed the same day as an E/M service. Injectable drugs can be billed separately.

Do not bill for injectable drugs if part of the 340B/VFC Drug Pricing Program.

**VIII. Venipuncture**

Use the appropriate code to report the therapy specified:

- 36415 Collection of venous blood by venipuncture
- 36416 Collection of capillary blood specimen (eg. Finger, heel, ear stick)

**IX. COVID-19**

If receiving reimbursement/funding from another entity (KDHE, grants, etc.) to provide COVID-19 testing services do not submit a claim to BCBSKS. More information regarding COVID-19 can be found on our COVID-19 Provider Information webpage.

**X. Completing a 1500 Claim Form**

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

**XI. Reference Materials**

- ICD-10-CM. Optum 2020
## Revisions

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<td>01/01/2019</td>
<td>Redesigned manual.</td>
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<td>Page 9 – Updated price for 90474.</td>
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<td>01/01/2020</td>
<td>Page 3 – Updated name of claims-filing software.</td>
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<td>Page 4 – Added paragraph to clarify code selection within scope.</td>
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<td>Page 3 – Updated verbiage of General Information to reflect current practices.</td>
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