2025 Insurance Biller's Seminar

Institutional and Professional Providers

BlueCross BlueShield Kansas

Agenda

- Provider Relations department re-organization
- CAP and contract mailing
- General provider information
- Institutional provider
- Professional provider
- Blue Medicare Advantage
- Tricare/TriWest
- Healthy Blue

Provider Relations Department Reorganization

Provider Network Solutions

CAP and Contract Mailing

- Annual contract update
- Provider contract is perpetual
- Approved by Board of Directors at BCBSKS
- Emailed towards the end of July
- Reimbursement updates
- Provider types / specialties / tiers
- Quality Based Reimbursement Program (QBRP)

General Provider Information

Prior Authorization

Prior authorization - The process of obtaining prior approval from a health plan for services that require such approval based on the provider and/or member contract.

Example: Authorization required such as Rx

Predetermination

Predetermination - a documented response to an electronic/written request for review of available benefits and the medical necessity of service(s) requested prior to the service being rendered. This is a courtesy review and is NOT required by the member or provider contract.

Example: Confirming medical policy is met

Precertification

Precertification - The process of obtaining prior approval from a health plan for services that require such approval based on the provider and/or member contract.

Example: In-patient hospital stay

Electronic Precertification

Electronic precertification - Is a requirement to earn QBRP incentives for institutional providers. You can only electronically precert inpatient admissions at this time. Call in precerts are still necessary for inpatient rehab services, home health and hospice.

Example: In-patient Admission

BCBSKS Provider Portal Attestation

- Consolidated Appropriations Act (CAA)
- 90-day attestation requirement
- Separate from Availity portal
- Group and individual provider attestation

Remittance Advice

- Located in Blue Access via Availity
- Includes details on finalized claim
- Claim adjustment reason codes (CARC)
- Remittance advice remark codes (RARC)
- https://x12.org/codes

BCBSKS ID Cards

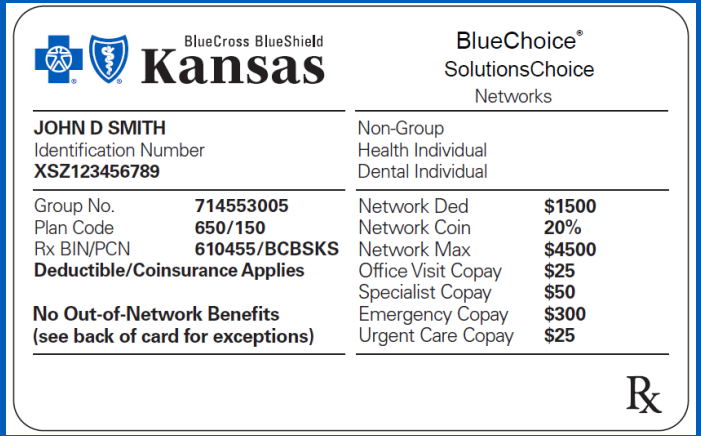
- Majority have a three-digit prefix (i.e.. XSB, KSE)
- Suitcase (PPO, PPOB, empty, MA PPO, no logo)
- No Suitcase (EPO) – No BlueCard benefits – can't travel
- Co-pays and deductibles listed
- Medical and dental (if applicable)
- Group number
- CSC phone number on the back

BlueCare EPO

- Product sold on the Marketplace
- Non-emergent, out-of-area care requires a prior authorization
- Covered benefits are for the BCBSKS service area
- Request to receive service outside of Solutions Network form
- Zero coverage if the member is referred to a non-contracting entity for any service, including lab and radiology
- Special contract with The University of KS Health System (KU Med in KC) and Children's Mercy

Prefixes for EPO members

- XSN – Individual on Exchange
- XSZ – Individual off Exchange
- KSA – Small Group off SHOP



BlueCard

- BlueCard program serves BCBS members worldwide
- "BlueCard" is the term used for out-of-state plans
- One source (Host Plan) for providers for claims submission
- Claim filing – All medical claims for out-of-state Blue Plans file to BCBSKS
- Terminology
  - Home Plan: The BCBS plan where the patient's policy was issued.
  - Host Plan: The BCBS plan where the services are rendered.

Risk Adjustment

- Diagnosis (dx) coding is the primary indicator for risk adjustment calculation and auditing
- When a claim record does not equal the clinical reality of patient's overall health, this creates a gap in the risk score.
- Dx specificity is critical for an accurate risk adjustment score
- Current dx code vs. history dx code
- Validate dx codes to medical record documentation
- Risk Adjustment Data Validation Audit

Reimbursement Reminders

- BCBSKS accepts AMA-CPT, HCPCS, ICD-10, DRG and revenue codes
- Unit limitations
- Medical policies
- Preventive service guide
- Limited patient waiver

Other Party Liability (OPL)

- Determines if services are eligible for coverage under another provider.
  - Verified annually for members and/or dependents.
  - Verifies if injuries/certain conditions are eligible under work comp or auto insurance.
- Helps contain costs that affect rates paid by members.
- Does not coordinate with Medicare or Medicaid.
- Checks for:
  - Duplicate coverage
  - Workman's compensation
  - No-fault auto

Important Contact Information

BlueCross BlueShield Kansas

Customer Service Center (CSC)

Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.

Questions regarding:
- Claim status
- Appeals
- Pre-determinations
- Benefits
- Eligibility

Contacts:
Email: csc@bcbsks.com
Phone: 800-432-3990 or 785-291-4180
Fax (written inquiries and predets): 785-290-0711
Fax (all others): 785-290-0783

CSC Providers Only Benefits Line

Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.

Questions regarding:
- Benefits
- Eligibility

Contacts:
Email: csc@bcbsks.com
Phone: 800-432-0272 or 785-291-4183

Provider Network Services

Hotline Hours: Monday-Wednesday, and Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Contracting
- Credentialing
- Network enrollment

Contacts:
Email: prof.relations@bcbsks.com
Phone: 800-432-3587 or 785-291-4135
Fax: 785-290-0734

Availity® Essentials

Office Hours: Monday - Friday 7:00 a.m. - 6:00 p.m.

Contact Availity Client Services toll free at 800-Availity (800-282-4548) or log in to Availity Essentials to submit a support ticket.

Availity Client Services is available during the hours listed above.

BlueCard®

Eligibility for out-of-state members:
- Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.
- Phone: 800-676-BLUE (800-676-2583)

Claim info for out-of-state members:
- Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.
- Phone: 800-432-3990, ext. 4058

Case Management

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Assistance with coordination of care for patients with complicated health issues.

Contacts:
Phone: 800-432-0216, ext. 6628 or 785-291-6628
For FEP members: 800-782-4437, ext. 6611

MiResource

Contacts: Email: support@miresource.com

Lucet

Office Hours: 24/7/365

Questions for behavioral health care:
- Preauthorizations
- Outreach services for high-risk patients
- Coordination with behavioral health care

Contacts:
Phone: 800-952-5906
Fax: 816-237-2364

Medicare Advantage

Office Hours: Monday - Friday 8:00 a.m. - 6:00 p.m.

KS members or M3A prefix
- Provider Services: 800-240-0577 Fax: 800-976-2794
- Prior Authorization/Utilization Management/Care Transition: 800-325-6201 Fax: 877-218-9089
- After Hours Utilization Management/Care Transition: 800-331-0192 Fax: 877-218-9089
- Behavioral Health Services (Lucet): 877-589-1635
- Hearing Services: 800-334-1807
- Vision Services: 877-226-1115

Federal Employee Program (FEP) - All FEP inquiries except OPL

Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.

Contacts:
Phone: 800-432-0379 or 785-291-4181
Fax: 785-290-0764

FEP Blue Dental Contacts:
Phone: 855-504-2583
www.bcbsfepdental.com

Electronic Data Interchange (ASK-EDI) - Payor ID: 47163

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Electronic claims transmission
- Electronic RA
- Billing software
- Clearinghouse services
- Internet file transfer and passwords
- Real-time vendors

Contacts:
Email: askedi@ask-edi.com
Website: ask-edi.com
Phone: 800-472-6481 or 785-291-4178
Fax: 785-290-0720

Fraud Hotline

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Reporting of any illegal activity involving BCBSKS. Callers may remain anonymous.

Contacts:
Phone: 800-432-0216, ext. 6400 or 785-291-7000, ext 6400.

Other Party Liability (OPL) & Pre-Existing

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Duplicate coverage
- No-fault auto exclusion
- Subrogation
- Workers' compensation
- Pre-existing

Contacts:
Phone: 800-430-1274 or 785-291-4013
Fax: 785-290-0771

Pre-certification, Concurrent Review and Alternate Care

Office Hours: Monday - Friday 8:00 a.m. - 5:00 p.m.

Questions regarding:
- All hospital inpatient admissions

Contacts:
Phone: 800-782-4437

Teleorder

Office Hours: 24/7/365

Contacts:
Phone: 800-346-2227 or 785-291-8130

Location Address:
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Billing Address:
P.O. Box 239
Topeka, KS 66601-0239

Availity

Availity Customer Support (1-800-282-4548) for:

- Registration (Availity.com)
- Password issues
- Changes/updates to Availity provider profile
  - TIN / NPI changes
  - Name / address changes
- Questions regarding other payers

Availity/BlueAccess - BCBSKS

Availity:

- Eligibility and benefits
- Claim status

BlueAccess:

- Patient ID search: for BCBSKS members
- Provider information
- Provider information forms: Attestation, Business Associate Agreements (BAA), Electronic Message Portal
- Remittance advice: View / print remits
- QBRP: QBRP earned report
- Resources (i.e. EFT enrollment)

Business Associate Agreement (BAA)

- Required if you have a 3rd party entity representing your practice or to attest to not having any current business arrangements
- Protects personal health information (PHI) and/or personal identifying information (PII)
- Located in BlueAccess via Availity, BCBSKS provider secure section (BlueAccess), provider information, business arrangements

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Electronic Provider Message Portal

- Upload records as requested
- Replaces receiving a more information request letter
- Located in BlueAccess
- Response required within 15 days of request
- Email notifications are sent every Monday

Electronic Funds Transfer (EFT)

- Quicker payment
- Less paperwork
- Located in BlueAccess via Availity, BCBSKS provider secure section (BlueAccess), resources, forms, professional or institutional, electronic fund transfer (EFT) form
- Upon enrollment with BCBSKS, network providers will be required to sign up for EFT payment

Institutional Providers

Quality Based Reimbursement Program

Institutional Quality Based Reimbursement Program (QBRP)

What is QBRP?

QBRP is a voluntary incentive program to incentivize quality and safety, and to reward providers for superior quality outcomes and cost efficiency.

- Additional revenue opportunity for meeting quality metrics.
- Data reported biannually to qualify.

Institutional Quality Based Reimbursement Program (QBRP)

A Collaborative Approach to Selecting Measures

BCBSKS works with Kansas Hospital Association (KHA) and Kansas Healthcare Collaborative (KHC) to select meaningful quality and efficiency measures for providers.

BCBSKS strives to select and align with existing quality measures reported in Kansas for national and state led quality initiatives. Such initiatives include:

- Compass Hospital Quality Improvement Contractor (HQIC)
- Medicare Rural Hospital Flexibility (FLEX) programs
- Medicare Beneficiary Quality Improvement Project (MBQIP)

CAH QBRP 2025

Measure Description		Benchmark	Source
QM1	Adverse Drug Event		KHC HQIC
QM2	Clostridioides difficile		NHSN
QM3	Catheter Associated Urinary Tract Infection Rate (CAUTI)	≤ 1.00%	NHSN
Implementation of the below Clinical Data Submissions via HL7 or CCD (but not			
QM4	HL7 V2 (HL7 Bundle) OR HL7 V3 (CCD Bundle)		BCBSKS
QM5	Antimicrobial Stewardship		KHC HQIC
QM6	Hand Hygiene Adherence Compliance	≥93.00%	NHSN
QM7	Unplanned All-Cause Readmissions	≤10.00%	KHC HQIC/QHi Core
QM8	Healthcare Associated Infections	≤ 0.50%	KHC HQIC/QHi Core
Patient and Family Engagement and Health Equity Metrics			
QM9	Patient and Family Engagement Bundle	4/5	KHC HQIC
QM10	Hospital Commitment to Health Equity Measures		MBQIP
QM11	Screening for Social Determinants of Health Measure (SDOH)		MBQIP
QM12	Screen Positive for Social Determinants of Health Measure (SDOH Screening Positive)		MBQIP
QM13	Emergency Department Transfer Communication	≥ 79.00%	MBQIP
QM14	Severe Sepsis/Septic shock 3-hour Management Bundle	≥50.00%	PQM 0500
QM15	Falls with Injury	≤ 0.50%	KHC HQIC
QM16	HCAHPS – Overall Rating of Hospital	≥ 70.00%	MBQIP
QM17	CMS Birthing Friendly Hospital		CMS
Total incentive possible without Low Volume incentives			
QM18-22	LOW VOLUME – must report 1,900 or fewer inpatient days on most recent Medicare Cost Report. Attend up to 5 quality related educational events and earn between 1.00% and 4.60% for each event.		

PPS QBRP 2025

Measure Description		Benchmark	Source
QM1	Adverse Drug Event		KHC HQIC
QM2	Clostridioides difficile		NHSN
QM3	Electronic Continued Stay Reviews (CSR)	≥ 70.00%	BCBSKS
QM4	Catheter Associated Urinary Tract Infection Rate (CAUTI)	≤ 0.25%	NHSN
QM5	Central Line Associated Blood Stream Infection (CLABSI)	≤ 0.10%	NHSN
Implementation of the below Clinical Data Submissions via HL7 or CCD (BUT NOT BOTH			
QM6	HL7 V2 (HL7 Bundle) OR HL7 V3 (CCD Bundle)		BCBSKS
QM7	Hand Hygiene Adherence Compliance	≥ 93.00%	NHSN
QM8	Unplanned All-Cause 30-day Readmissions	≤10.00%	KHC HQIC/QHi Core
Patient and Family Engagement and Health Equity Metrics			
QM9	Patient and Family Engagement Bundle	4 / 5	KHC HQIC
QM10	Hospital Commitment to Health Equity		IQR
QM11	Screening for Social Determinants of Health Measure (SDOH Screening)		IQR
QM12	Screen Positive for Social Determinants of Health Measure (SDOH Screening Positive)		IQR
QM13	Antimicrobial Stewardship		KHC HQIC
QM14	Severe Sepsis/Septic Shock 3-hour Management Bundle	≥50.00%	PQM 0500
QM15	Falls with Injury	≤ 0.50%	KHC HQIC
QM16	Early Elective Deliveries	≤ 1.50%	PC-01
QM17	CMS Sole Community Hospital Designation		CMS
QM18-QM19	Blue Distinction/Blue Distinction Plus Designation		BCBSA
QM20-QM22	CMS Star Rating	≥3	CMS
QM23	Medicare Low Volume Status		CMS
Total incentive possible without Low Volume incentives			
QM24 – QM28	LOW VOLUME – must report 1,900 or fewer inpatient days on most recent Medicare Cost Report. Attend up to 5 quality related educational events and earn between 1.00% and 4.60% for each event.		

Rural Emergency Hospitals (REH) QBRP 2025

Measure Description		Benchmark	Source
QM1	Adverse Drug Event		KHC HQIC
QM2	Antimicrobial Stewardship		KHC HQIC
QM3	Hand Hygiene Adherence Compliance	≥93.00%	NHSN
Implementation of the below Clinical Data Submissions via HL7 or CCD (but not l			
QM4	HL7 V2 (HL7 Bundle) OR HL7 V3 (CCD Bundle)		BCBSKS
QM5	Healthcare Associated Infections	≤ 0.50%	KHC HQIC/QHi Core
QM6	Emergency Department Transfer Communication	≥ 79.00%	MBQIP
QM7	Falls with Injury	≤ 0.50%	KHC HQIC
QM8	Median Time from ED Arrival to ED Departure	≤180 minutes	MBQIP / OQR
QM9	Abdomen CT-Use of Contrast Material		OQR/CMS
QM10	Facility 7-day Risk rate after outpatient colonoscopy	≤1.00%	OQR/CMS
QM11	Hospital visit after hospital outpatient surgery	≤15.00%	OQR/CMS

QBRP Reporting Dates

Reporting Periods

- Period 1 is due by November 5, 2024
- Period 2 is due by May 5, 2025

Low Volume Incentive

- The number entered on your attestation form is taken from line 1, column 8 of the S-3 worksheet.
- Qualifying events must be from 5/1/24 to 10/31/24 for Period 1 and 11/1/24 to 4/30/25 for Period 2.

CSR Dates

- Period 1 CSRs will come from submissions between 5/1/2024-10/31/2024
- Period 2 CSRs will come from submissions between 11/1/2024-4/30/2025.

Data Submissions

- Period 1 data is gathered from discharges between 1/1/2024 to 6/30/2024
- Period 2 data is gathered from discharges between 7/1/2024 to 12/31/2024

Effective Dates

- Period 1 incentives will be effective January 1, 2025
- Period 2 incentives will be effective July 1, 2025

BlueCross BlueShield Kansas

bcbsks.com

Pre-service Reviews

Types of Pre-service Reviews

- Prior Authorization
  - Contract language – The Contracting Provider agrees to prior authorize outpatient services when implemented by BCBSKS or other Blue Cross and Blue Shield plans. Failure to prior authorize services may result in penalties assigned to the Contracting Provider.
- Predetermination
  - Contract language –The Contracting Provider shall not bill members for services which have been determined medically unnecessary, experimental/investigational, have been denied due to Utilization Review, and/or are patient demanded services unless the member has been given written notification in advance of services being provided, that specific services will be the member's responsibility. Contracting Providers are strongly encouraged to use the Limited Patient Waiver (LPW). Generic or all-encompassing notifications without advanced written authorization by BCBSKS shall not be deemed to meet the specific notification requirement mentioned above. In instances where medical necessity is questionable, the Contracting Provider may contact BCBSKS medical review department for a predetermination of coverage. This provision applies to inpatient, outpatient and partial-day services.
- Precertification
  - Contract language – 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. Hospitals will accomplish this through the electronic precertification system.

Pre-service Reviews

- Roughly 75% of all pre-service review requests BCBSKS received last year were submitted by providers voluntarily. BCBSKS offers predeterminations as a courtesy to providers – it is not required.

- BCBSKS requires pre-service review for the following services:
  - Inpatient medical stays
  - Inpatient mental health stays
  - Home health and hospice services
  - Transplants, with the exception of cornea and kidney
  - Human growth hormone
  - Germline genetic testing
  - Certain prescription drugs

Note: Some self-funded employer groups may have specific items that require prior authorization. These services are at the discretion of the employer -- not BCBSKS.

Payment Integrity: Ensuring Claims Accuracy and Payment

What is Apixio?

Apixio is an independent national review firm selected by BCBSKS as part of the Payment Integrity Initiative of the Blue Cross and Blue Shield Association.

The Payment Integrity Initiative aims to ensure accurate processing and payment of claims.

Apixio has been engaged to perform post-pricing pre-pay adjudication on Diagnosis Related Group (DRG) claims.

What is the Apixio Provider Portal?

The Apixio Provider Portal is a tool utilized by providers to upload medical record documentation and access patient claim review findings from Apixio.

- Unique URL to access the portal
- Only able to view your specific claims
- Medical records must be uploaded within **eight** days for Host (BlueCard) claims and **23** calendar days for Home (non-BlueCard) claims or **claim will be denied**

For more information on how to use the Apixio Provider Portal, visit bcbsks.com/providers/institutional/resources.

For additional education, please reach out to your provider representative.

Billing Reminders

- Accident billing
- Outpatient bundling rules
- Claims pricing

NUBC guidelines

The National Uniform Billing Committee (NUBC) makes a complete Official UB-04 Data Specifications Manual available by subscription.

This manual contains the updated specifications for the data elements and codes included on the UB-04 claim form and used in the 837I transaction standard.

BCBSKS accepts all valid NUBC codes.

Professional Providers

Quality Based Reimbursement Program

Quality Based Reimbursement Program

- Designed to promote efficient administration, improved quality and better patient care and outcomes with opportunity to earn additional revenue when meeting quality measures
- Details are in the CAP report
- Four prerequisites (claims, remits, newsletters, and be in good standing with BCBSKS)
- Groups A, B & C
- Qualifying periods for each measure – Quarterly/semi annual
- Incentive excluded for clinical lab, pharmacy and pharmaceuticals and dental services

Policy Memos

Policy Memos

1. Policies and Procedures
2. Office/Outpatient
3. Outpatient Treatment of Accidental Injuries
4. Quality of Care
5. In-Hospital Medical
6. Concurrent Professional Care
7. Radiology and Pathology
8. Obstetrical Services
9. Surgery
10. Assistant Surgery
11. Multiple Surgical Procedures
12. Anesthesia

Policy Memo #1

Policies and Procedures

Retrospective Claim Review

- 120 days from date of remittance advice
  - Written inquiry
    https://secure.bcbsks.com/bcbsks-provider/facelets/allUsers/form/ProviderClaimEnrollmentInquiry.faces
- Void claim
  - CMS 1500: Box 22 use #8 claim frequency code indicator and ICN #
- Corrected claim
  - CMS 1500: Box 22 use #7 claim frequency code indicator and ICN#

Appeals – only “not medically necessary" denials

- 1st Level: Written notification within 60 days from retrospective review determination
- 2nd Level: Written request within 60 days from 1st level appeal

Audits

- Post Pay Audits
- Fraud and Abuse
- Utilization
- Risk Assessment

Content of Service

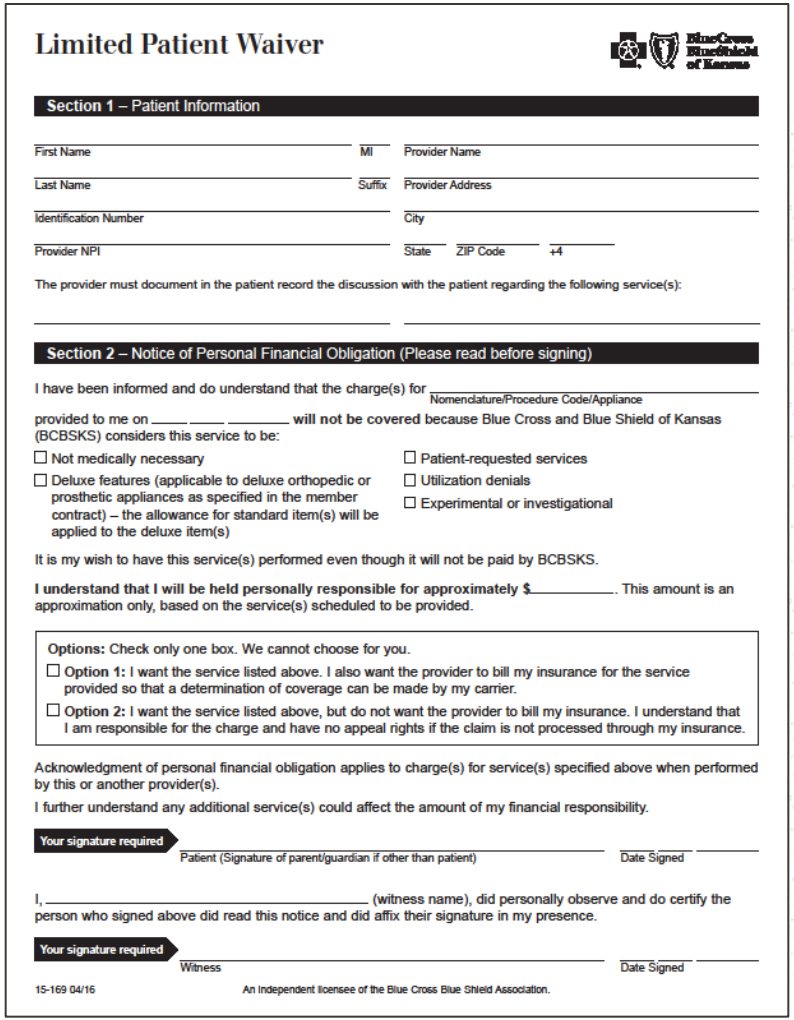
- Therapeutic, prophylactic or diagnostic injection administration provided on the same day as an office, home or nursing home visit
- Telephone calls & web-based correspondence
- Additional charges beyond the regular charge. Ex – after office hours, holidays or emergency
- A list is in Policy Memos 1 and 2 (not all-inclusive)

Non-covered Services

Professional services are not reimbursed when provided to an immediate family member – spouse, children, parents, siblings, or legal guardian of the person who received the service (or themselves).

Member's contract may determine categories of services, procedures, equipment and/or pharmaceuticals. These denials are billable to the member.

Limited Patient Waiver



Limited Patient Waiver

Blue Cross Blue Shield of Kansas

Section 1 – Patient Information

First Name | MI | Provider Name

Last Name | Suffix | Provider Address

Identification Number | City

Provider NPI | State | ZIP Code | +4

The provider must document in the patient record the discussion with the patient regarding the following service(s):

Section 2 – Notice of Personal Financial Obligation (Please read before signing)

I have been informed and do understand that the charge(s) for _____
Nomenclature/Procedure Code/Appliance

provided to me on ____ ____ _____ **will not be covered** because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service to be:

- ☐ Not medically necessary
- ☐ Deluxe features (applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) – the allowance for standard item(s) will be applied to the deluxe item(s)
- ☐ Patient-requested services
- ☐ Utilization denials
- ☐ Experimental or investigational

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS.

I understand that I will be held personally responsible for approximately $_____. This amount is an approximation only, based on the service(s) scheduled to be provided.

Options: Check only one box. We cannot choose for you.

- ☐ **Option 1:** I want the service listed above. I also want the provider to bill my insurance for the service provided so that a determination of coverage can be made by my carrier.
- ☐ **Option 2:** I want the service listed above, but do not want the provider to bill my insurance. I understand that I am responsible for the charge and have no appeal rights if the claim is not processed through my insurance.

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

Your signature required _____ Date Signed _____
Patient (Signature of parent/guardian if other than patient)

I, _____ (witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

Your signature required _____ Date Signed _____
Witness

15-169 04/16 An Independent licensee of the Blue Cross Blue Shield Association.

Documentation

- Chief complaint
- Complete S.O.A.P. or M.E.A.T
- Abbreviations – Have a legend
- Diagnosis and Dx code
- Electronic vs. handwritten signature
- Time-based coding – Time in & time out or total time

Uniform Charging

What constitutes a provider's usual charge?

- Discount to every patient without health insurance
- You must bill BCBSKS the same amount

Concierge/Club services are not to be offered to BCBSKS members

Are discounts acceptable?

- Based upon an individual patient's situation
- Community mental health centers and county health departments are allowed to use a sliding scale due to agency regulations
- Only collect deductible, co-payment, co-insurance or non-covered services at the time of service

Non-contracting Provider

- A contracting provider must bill for any services ordered and performed by a non-contracting provider.
- The contracting provider must hold the member harmless.
- If a member requests referral to a non-contracting provider, a signed statement of financial obligation should be on file.
- Contracting/ordering provider must bill BCBSKS for all services rendered by the non-contracting provider.
- Contracting/ordering provider will be required to ensure the member is held harmless if billed by the non-contracting provider.

Claims Filing

- Contracting provider agrees to file claims for all covered services
- Timely filing
  - BCBSKS - 15 months from date of service or discharge from hospital
  - FEP - by Dec. 31 of the year after the year the service was received
  - ASOs - may have different timely filing requirements
- Eligible contracting providers must file services under their own billing NPI
- BCBSKS does not recognize “incident to”
- Use current diagnosis and procedure codes

Claims Filing

- Corrected claims are considered the retrospective review
  - Resubmission code 7 and original claim number
  - Do not write "corrected claim" on the claim form
- Void claim
  - Resubmission code 8 and original claim number
  - Wait for verification of voided claim on remittance advice
- New claim

Modifiers

- Modifier 59
  - Lesion Removal (10000's) and Radiology Codes (70000's) only
  - BCBSKS doesn't recognize it like Medicare
- Modifier 22
  - Drop claim to paper and attach records (unless lab/path handling fee)
- Modifier 25
  - Established patient E/M code (not new patient E/M)
  - Reduces the E/M by 25 percent MAP.
  - Do not use when billing 96372 (therapeutic injection)

Refund & Right of Offset Policy

- BCBSKS must request refunds within 15 months from the date of adjudication.
- Refund requests for fraudulent claim payments and duplicate claim payment, including other party liability claims, are not subject to the 15-month limitation.
- BCBSKS uses auto deduction processes for Right of Offset for claims previously paid.

Locum Tenens Provider

- BCBSKS allows use of a Locum Tenens
  - Provider must be same type of a provider for whom the locum is substituting for
  - Locum Tenens must be licensed in the state of KS
  - No longer than 60 days
  - Billing: use NPI of the provider for whom the locum tenens is substituting. Add Q6 modifier.
  - Medical record must indicate the services were provided by a locum tenens
  - Can not use Locum Tenens for a provider who has passed away

Policy Memo #2

Office/Outpatient Visits

- New vs. established patient
- Content of service
- Outpatient consultations
- Telemedicine
  - POS 02 or 10 / GT modifier
  - Provider must be licensed in the state the patient is located at time of service
  - Telemedicine is service with audio, visual or audio/visual – Does not include emails, faxes or texts

Policy Memo #3

Outpatient Treatment of Accidental Injuries and Medical Emergencies

- Accident claims
  - Accident indicator
  - Accident date / qualifier
  - Accident Dx - primary

Policy Memo #4

Quality of Care

- Quality improvement program
- Disease Management
  - bcbsks.com/BeHealthy/DiseaseMgmt
  - bcbsks.com/Behealthy/Wellness-Management
- HIPAA
- Credentialing
  - CAQH – Standardized credentialing application for KS

Policy Memo #5

In-hospital Medical (non-surgical) Care

- Daily hospital services (new or established patient)
- In-hospital consultations

Policy Memo #6

Concurrent Professional Care

- No modifiers needed
- Doesn’t apply to:
  - Radiology
  - Pathology
  - Dx endoscopies
  - Asst surgeries
  - Admin of anesthesia
  - Single consultations

Policy Memo #7

Radiology and Pathology/Laboratory Services

- Radiology and pathology
- Diagnostic radiology
- Therapeutic radiology
- Pathology – not subject to ancillary guidelines
- Handling fee (CPT 99000)
- Clinical lab – follow ancillary guides
    - Claim filed to the Blue Plan in the state where the referring/ordering provider resides

Policy Memo #8

Obstetrical Services

- OB services non-surgical
  - Total OB care
  - Antepartum care
  - Delivery
  - Postpartum care
- OB services surgical
- Services qualifying for additional fees
  - Usual fee for antepartum care doesn't include lab services except for the UA

Policy Memo #9

Surgery

- Global fee concept

- Major – one day before, day of the procedure and six weeks (42 days) following
- Minor – day of the procedure and ten days following
- Zero – day of the procedure
  - Modifiers
  - Physicians in group practice
  - Adverse events

Policy Memo #10

Assistant Surgery

- Medical necessity
- Reimbursement
- Non-physician assistants

Policy Memo #11

Multiple Surgical Procedures

- Performed by one provider
    - Allow procedure with higher RVU at 100%, other procedures at 50%
- Surgical scope procedures
    - Two or more scope procedures involving multiple compartments of the same anatomic area – only the procedure with higher/highest RVU will be allowed, the others are content of service

Policy Memo #12

Anesthesia

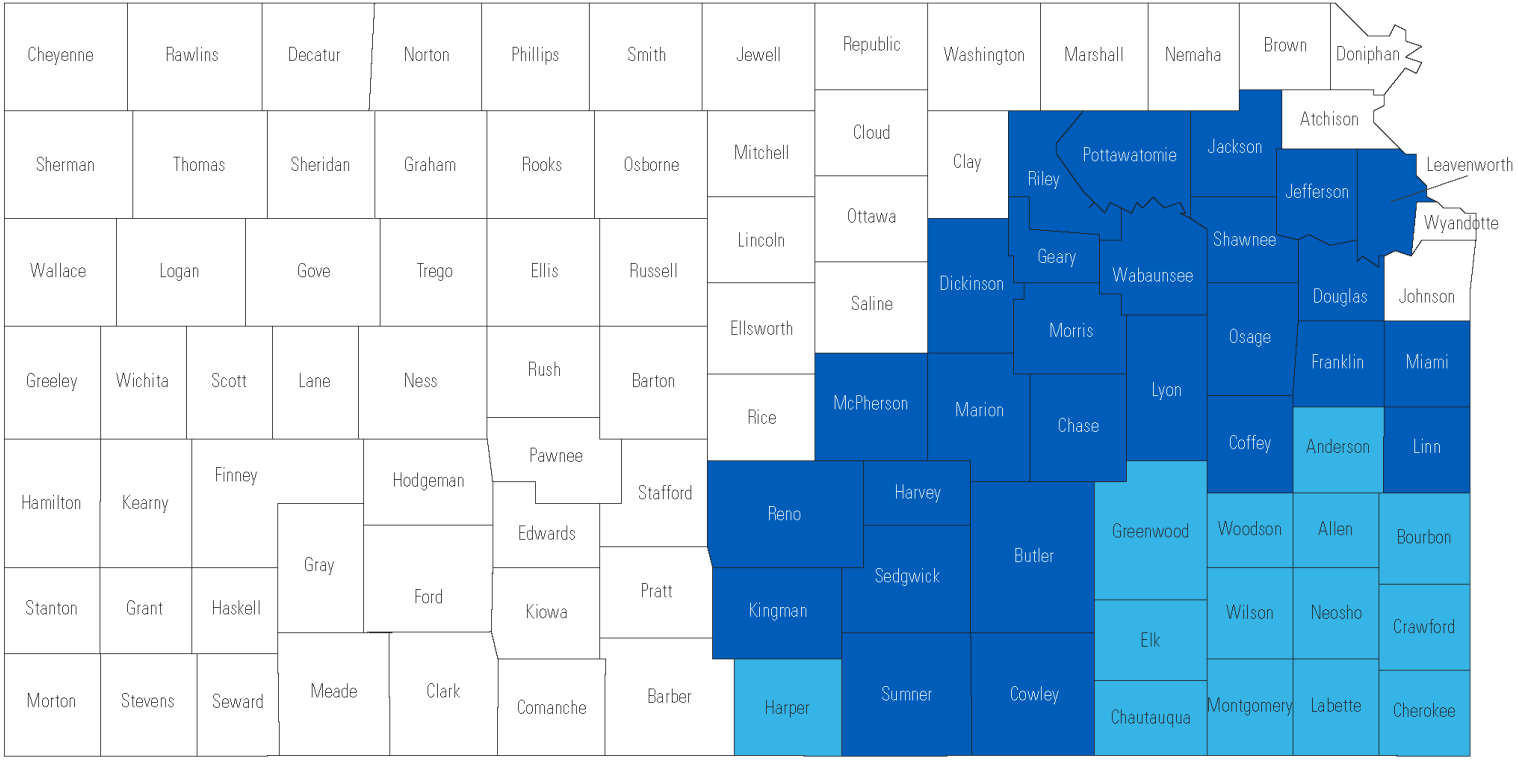
- Time of administration
- Content of service
- Nerve blocks
- Maximum allowable payment (MAP)
- OB epidural
- Monitored anesthesia
- Moderate (conscious) sedation

Medicare Advantage (MA)

Medicare Advantage

- 27 Counties, including Sedgwick and Shawnee
- Medicare rates and policies apply
- No additional premiums for added services
- Not included in the QBRP program
- Prefix – M3AK

Medicare Advantage Update



New counties

Current counties

Operating in **27** counties

Total enrollment: More than **4,300**

Star Rating: **4**

MA | PPO
MEDICARE ADVANTAGE

Tricare/TriWest

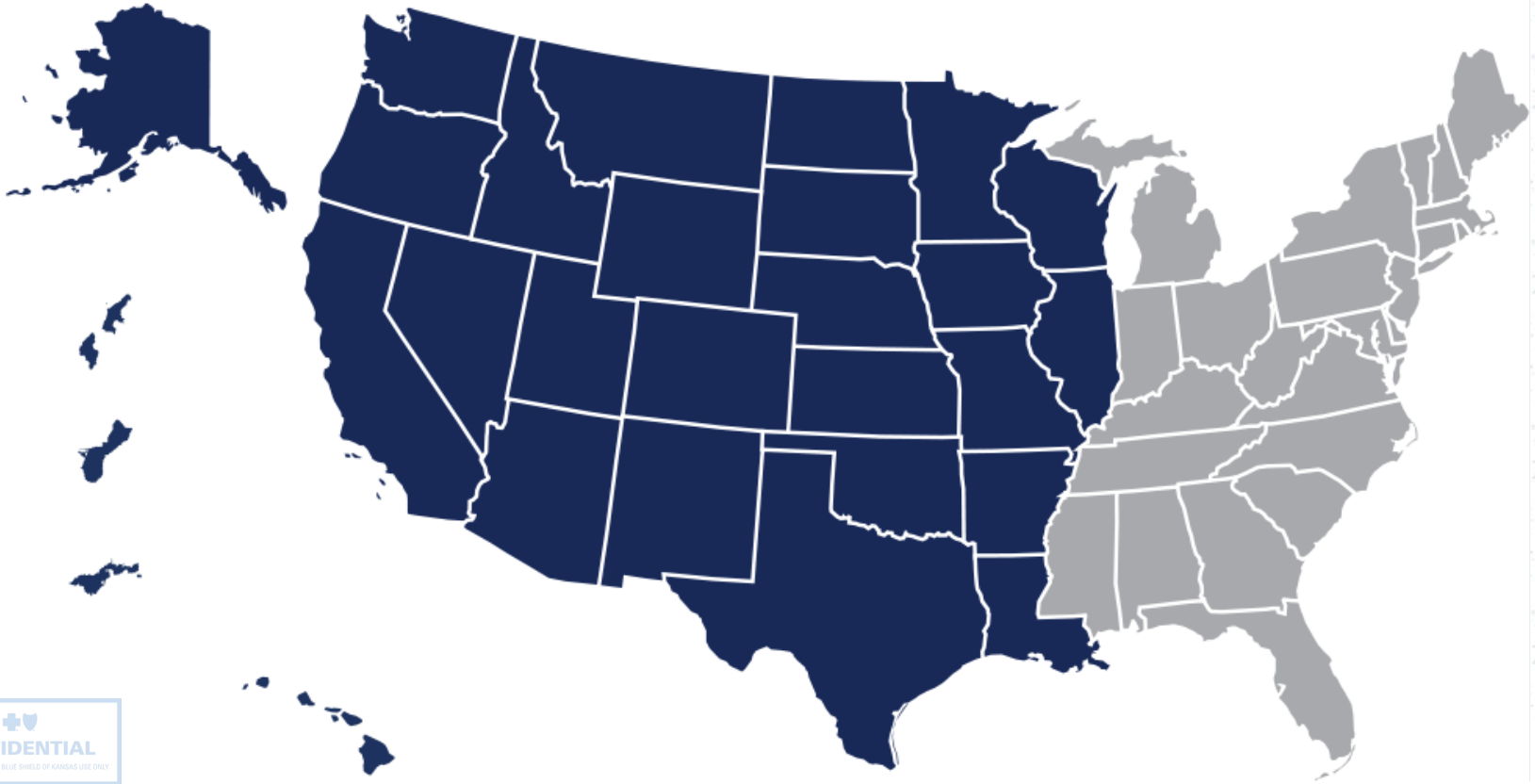
TRICARE

- BCBSKS has partnered with TriWest Healthcare Alliance (TriWest) to deliver a high-performing network of providers to serve military members and their families through the Department of Defense TRICARE fifth Generation (T-5) contract.
- Start of healthcare delivery for the next generation of TRICARE is to begin in the West region Jan. 1, 2025.
- triwest.com/en/provider/

TRICARE covers:

- Active-duty service members and their family
- National Guard, reservists and their family
- Retirees and their family
- Survivors
- Certain former spouses

West Region – 26 states



Healthy Blue

Healthy Blue

- Partnership with BlueKC and Anthem Partnership Holding
- Serves the Kansas Medicaid population
- Awarded contract in June 2024
- Contract effective 01/01/2025
- healthybluekansas.com

Highlights

80+ years in Kansas

Membership
Over 2 million Kansans already served by BCBSKS and Blue KC

Associates

2,000+
associates employed in Kansas

Foundation and social responsibility

$4.3M
annual 2022 giving in Kansas

300+ partnerships
with community organizations

3,842 volunteer hours
in 2022

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Electronic Data Interchange

ADMINISTRATIVE SERVICES OF KANSAS

EDI Help Desk

Available 7 a.m. – 4:30 p.m., Monday through Friday

1-800-472-6481, option 1

Email: askedi@ask-edi.com

Website: ask-edi.com

Please have the following information available when calling

- Billing NPI
- Seven-digit trading partner number (if available)

Claim inquiries

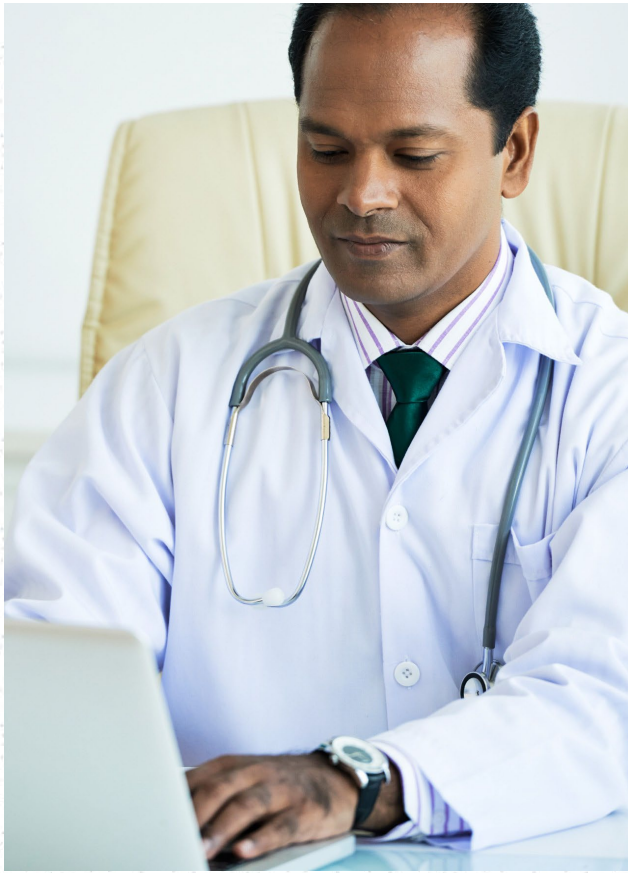
- Member ID, claim amount, date of service, account number

Remittance advice inquiries

- Check date, amount and number

Resources

- ask-edi.com
- INOVALON | PC-ACE
  - Free billing software
- X12 standardized HIPAA code sets
  - https://x12.org/codes
- Health care code lists
  - Claim status category codes
  - Claim status codes



Q&A Session

Thank you for being a BCBSKS contracting provider