

Health Department Billing Guidelines



Table of Contents

I. General Information.....	3
II. EDI.....	3
III. How to Read Member ID Cards	4
IV. Documentation Requirements/Medical Records	5
V. Billing and Coding Guidelines	9
VI. Unit Limitations	12
VII. Administration and Immunization Reimbursement	12
VIII. Administration of Other Injectables	13
IX. Venipuncture	13
X. Lab Claims.....	14
XI. COVID-19	14
XII. Completing a 1500 Claim Form	14
XIII. Reference Materials	14
Revisions.....	15

Acknowledgement – *Current Procedural Terminology* (CPT®) is copyright 2022 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT®. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

CPT® is a trademark of the American Medical Association.

HEALTH DEPARTMENT BILLING GUIDELINES

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

HEALTH DEPARTMENT BILLING GUIDELINES

- Comprehensive real time desktop editing provides immediate user feed back
- 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:

The diagram shows a BlueCross BlueShield of Kansas ID card for JOHN D SMITH. Callouts provide the following information:

- Prefix — identifies product and benefits:** Points to the ID number XSN123456789.
- Copay and deductibles:** Points to the Office Visit Copay (\$35), Specialist Copay (\$70), and Deductible (\$3000).
- Dental benefits — if blank, no dental coverage:** Points to the blank area where dental benefits would be listed.
- Suitcase logo — helps determine network and benefits:** Points to the BCBSKS DentalPlus logo.
- Prescription benefit — if blank, no prescription benefit:** Points to the blank area where a prescription benefit would be indicated.

This close-up shows the bottom of the ID card. A callout points to the blank area at the bottom, stating: "The absence of dental language at the bottom indicates no dental coverage."

This close-up shows the bottom of the ID card. A callout points to the blank area at the bottom, stating: "The EPO card has no suitcase logo, which signifies a lack of out-of-network benefits."

- Ask patient for current ID card at each visit.

HEALTH DEPARTMENT BILLING GUIDELINES

- 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 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.

HEALTH DEPARTMENT BILLING GUIDELINES

- 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.

HEALTH DEPARTMENT BILLING GUIDELINES

- 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

HEALTH DEPARTMENT BILLING GUIDELINES

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."

HEALTH DEPARTMENT BILLING GUIDELINES

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 medical decision making (MDM) or time as outlined in the AMA CPT® guidelines. These guidelines do not establish documentation requirements of standards of care. History and examination should still be completed and documented, as medically appropriate.

In a health department setting, time probably would not be a factor in determining the level of E&M code. If basing code selection on time, medical necessity must still be supported in the medical record or services may be denied or reduced. If basing code selection on time, the time must also be documented in the medical record.

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.

HEALTH DEPARTMENT BILLING GUIDELINES

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
- 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 & 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 Prostrate
 - Z12.5
- Contact with and (suspected) exposure to Meningococcus
 - Z20.811

VI. Unit Limitations

BCBSKS applies some limitations on the number of units billed for certain procedure codes. When a claim is submitted with units over what the limitation allows, BCBSKS will split the service into two-line items. The first line will reflect the maximum units allowed. The second line will contain the units billed in excess of the limitation.

VII. 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.

Vaccine/drug administration for BCBSKS members should be billed per CPT Guidelines found in the Medicine Section for immunization administration and immunization codes.

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

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

HEALTH DEPARTMENT BILLING GUIDELINES

Additional instructions for billing immunizations/vaccination codes:

Include the referring/ordering qualifier and NPI listed in box 17 of the 1500 Claim Form. For Health Departments without a MD/DO on-site, report the NPI of the doctor overseeing the Health Department.

Qualifier Codes:

Any claim with a radiology procedure (7XXXX), laboratory service (8XXXX), diagnostic (9XXXX), or HCPC (excluding Ambulance) will require an ordering/referring provider name and NPI in addition to the appropriate qualifier for box 17.

The Qualifiers for use in box 17 are:

- DN, referring provider
- DK, ordering provider
- DQ, supervising provider

The NPI of the referring, ordering or supervising provider should be entered in field 17b.

A list of remittance advice rejection codes can be found at <https://x12.org/codes>.

This will give you details on claim denials based on the standardized codes listed on the remittance.

VIII. 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.

IX. Venipuncture

Use the appropriate code to report the therapy specified

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

X. Lab Claims

Your contract with BCBSKS states that you are required to submit claims for all covered services (Policy Memo 1, Section XV).

If a member has a lab draw at the Health Department, the claim will need to be submitted to BCBSKS for that service and not billed to the member.

If the Health Department wants to be a "draw site only" for labs, the appropriate venipuncture code should be billed to BCBSKS. The lab will need to bill for their services separately.

Having BCBSKS members as "Self-Pay" for lab services and instructing them to submit their own claims is considered a violation of the provider contract.

XI. 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.

XII. Completing a 1500 Claim Form

For help with completing a 1500 claim form, a [tutorial](#) is available at bcbsks.com.

XIII. Reference Materials

- Current Procedural Terminology, ©2022 American Medical Association.
- ICD-10-CM. Optum 360 2022

HEALTH DEPARTMENT BILLING GUIDELINES

Revisions

01/01/2019	Redesigned manual.
	Page 9 – Updated price for 90474.
01/01/2020	Page 3 – Updated name of claims-filing software.
	Page 4 – Added paragraph to clarify code selection within scope.
	Page 10 – Updated allowances.
01/01/2021	Page 3 – Updated verbiage of General Information to reflect current practices.
	Page 4 – Removed Documentation Guidelines section.
	Page 5 – Updated/added information to How to Read Member ID Cards.
	Page 6 – Added Documentation Requirements/Medical Records section.
	Page 10 – Updated verbiage of Billing and Coding Guidelines to reflect current practices.
	Page 11 – Removed BCBSKS Professional Relations Representative section – Information moved to General Information section.
	Page 15 – Added Administration of Other Injectables section.
	Page 15 – Venipuncture section.
	Page 15 – Added COVID-19 section.
01/01/2022	Page 10 – Updated verbiage of Evaluation and Management Codes section to reflect current practices.
	Page 14 – Added Unit Limitations section
	Page 14 – Updated verbiage of Administration and Immunization Reimbursement to reflect current billing practices.
03/31/2022	Page 13 – Updated Administration and Immunization Reimbursement section to follow CPT Guidelines.
01/01/2023	Page 14 – Added section X. Lab Claims.
	Page 14 – updated section XII: Reference Materials to current references.



Visit us at bcbsks.com



1133 SW Topeka Blvd, Topeka, KS 66629

An independent licensee of the Blue Cross Blue Shield Association.