2026 Manual

Health Department Billing Guidelines

BlueCross BlueShield Kansas

bcbsks.com

Table of Contents

I. General Information

As a contracting provider with Blue Cross and Blue Shield of Kansas (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 member is available to visit your office to address any operational issues.
- Periodic workshops conducted by professional relations staff who deliver training and updates on new administrative procedures to help ensure timely claim payments.
- Provider Network Operations in Topeka is available at 785-291-4135 or 800-432-3587, or ProviderNetworkEnrollment@bcbsks.com.

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

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

II. 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 an RN should only be billed with CPT code 99211, regardless of level of E/M service provided.

In a health department environment, in which an MD, APRN, DO or PA are employed, a limited range of E/ M codes are 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 preventive visits. These codes are defined as a new or established patient and by age, and they can be found in the Preventive Services Guide. Preventive Services should only be billed when performed by an 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.

III. 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.

Codes for immunization administration for Vaccines/Toxoids should be reported on the same claim in addition to the vaccine/toxoid code(s).

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 an 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 x12.org. This will give you details on claim denials based on the standardized codes listed on the remittance.

IV. 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.

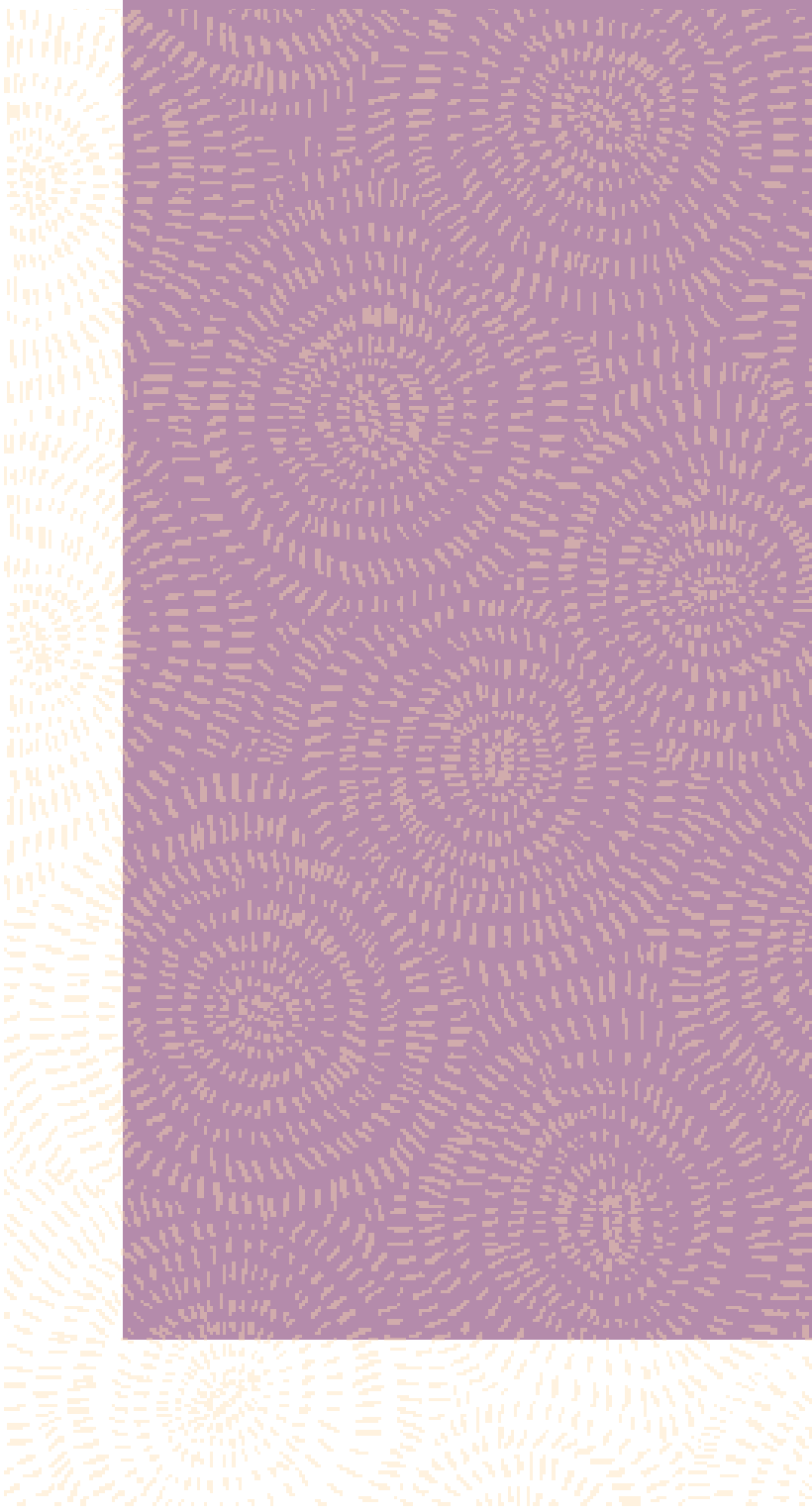
V. Completing a 1500 Claim Form

For help with completing a 1500 Claim Form, a tutorial is available at bcbsks.com

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 General Information section to reflect current practices
	Page 4 – Removed Documentation Guidelines section
	Page 5 – Updated How to Read Member IDs section
	Page 6 – Added Documentation Requirements/Medical Records section
	Page 10 – Updated Billing and Coding Guidelines section 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 – Added Venipuncture section
	Page 15 – Added COVID-19 section
01/01/2022	Page 10 – Updated Evaluation and Management Codes section to reflect current practices
	Page 14 – Added Unit Limitations section
	Page 14 – Updated 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 Reference Materials section to reflect current references
01/01/2024	Page 3 – Added new section I. Important Contact Information section – updated section numbers by one
	Page 4 – Section II – removed third bullet to reflect current services
	Page 12 – Removed ICD-10 CM Coding section
	Page 13 – Section VIII – added administration billed only information
	Page 14 – Updated Reference materials to reflect current references
	Page 14 – Updated Administration and Immunization Reimbursement section to clarify billing instructions
01/01/2025	Page 3 – Removed MiResource information
	Page 5 – Updated EDI section to reflect current free claims-filing software

	Page 11/12 – Clarified the Evaluation and Management Codes section
	Page 14 – Added information about receiving reimbursement from another entity
	Page 14 – Removed section XII COVID-19
	Page 15 – Removed section XIV Reference Materials
01/01/2026	Removed links throughout
	Page 3 – Removed Important Contact Information section
	Page 4 – Updated General Information section to reflect current information
	Page 5 – Removed EDI section
	Page 6 – Removed How to Read member ID Cards section
	Page 7 – Removed Documentation Requirements/Medical Records section
	Page 11 – Removed duplicate information in Billing and Coding Guidelines section
	Page 12 – Removed Unit Limitations section
	Page 13 – Removed Administration of Other Injectables section
	Page 14 – Removed Venipuncture section



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