

Professional Provider Manual

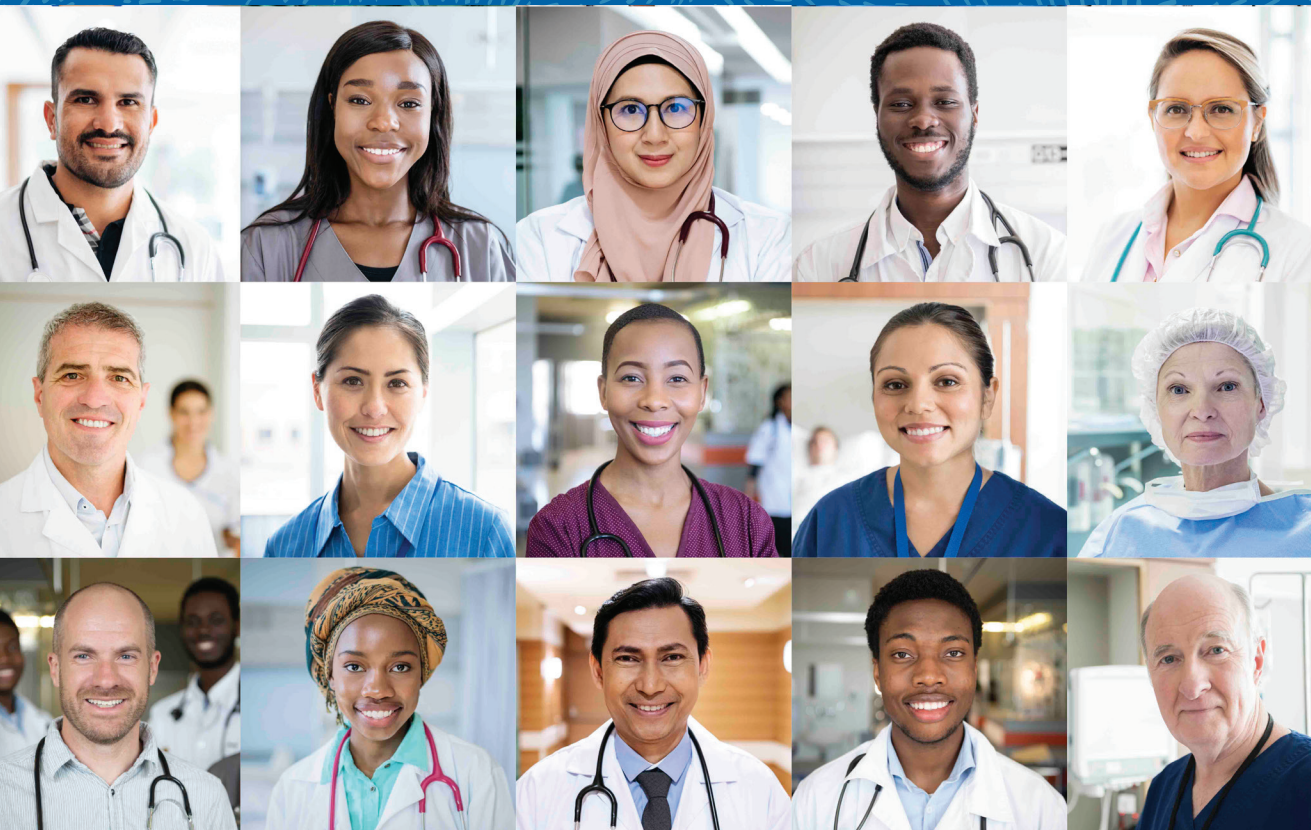


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About this Manual

As a Blue Cross and Blue Shield of Kansas (BCBSKS) contracting provider, you receive the services of a professional relations staff dedicated to providing you with easy-to-access information regarding policy memos and information.

This online manual provides detailed information about products, claim filing, reimbursement policies, specialty guidelines, and other important information used in your operation. The internal links allow you to point and click your way through the manual.

NOTE — The revision date appears in the footer of each document. Links within the document are updated as changes occur throughout the year.

We thank you for your participation in the BCBSKS CAP network.

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CAP and Policy Memos

Competitive Allowance Program (CAP)

- The Competitive Allowance Program (CAP) agreement is a contract between the provider and Blue Cross and Blue Shield of Kansas (BCBSKS).
- The CAP agreement is perpetual.
- Changes are made to the CAP program and are approved by the BCBSKS Board of Directors each year.
- The CAP documents (which contains a summary of changes for the upcoming year) are emailed in July which allows the provider time to decide if they wish to remain contracting.
- BCBSKS creates a Charge Comparison Report specific to the provider and reflects current codes billed to BCBSKS, current charge information, and the allowed charge for the upcoming year. Your charge comparison report is available upon request. A machine readable file is located on the BCBSKS website.

Policy Memos

BCBSKS Policy Memos apply to all contracting providers. Please review applicable policies at the links provided on the following pages.

Policy Memos (also referred to as Policies and Procedures) provide specific explanations for providers contained within the contracting provider agreements. This information is intended to supplement and further clarify the rights and obligations of both parties.

[No. 1: Policies and Procedures](#)

- Medical Review Processes
- Corrected Claim
- Retrospective Claim Reviews
- Denied Claims Appeals Procedure
- Post-Payment Audits
- Utilization Review & Medical Necessity
- Content of Service
- Experimental or Investigational Procedures
- Non-Covered Services
- Patient-Demanded Services
- Waiver Form
- Medical Records
- Uniform Provider Charging Practices
- Purchased Services
- Professional Services Coordinated with a Non-Contracting Provider
- Claims Filing
- Refund Policy
- Right of Offset
- Services Provided by Non-Physicians and Resident Physicians

- Locum Tenens Provider
- Contracting Status Determination
- New Techniques and Technology
- Reimbursement and Policy Changes
- Amendments to Policies and Procedures; Right to Terminate Contract
- Establishing and Amending Medical Policy
- Tiered Reimbursement and Provider Number Requirements
- Reimbursement for New Procedure Codes
- Reimbursement for Pharmaceuticals
- Reimbursement for Sleep Study Testing
- Reimbursement for Lesser Services
- Reimbursement for Quality
- Reimbursement for Site of Service
- Adverse Events
- Application of Contract
- Acknowledgment of Independent Status of Plan
- Acknowledgment of Balanced Budget Act of 1997
- Contract Scope of Services
- Charge Comparison Reports
- Pathology or Laboratory Services
- Special Provision Pertaining to Pended Claims
- Limited Provider Networks
- CAP Provider Directories
- Acknowledgment of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations
- Business Associate Form
- Vendor Offshore Outsourcing Acknowledgement & Attestation
- Acknowledgment of K.S.A. 44-1030
- Medicare Advantage Claims
- Limited Patient Waiver Form
- Collection of Payment
- Contract Amendment

No. 2: Office/Outpatient Visits

- Definitions – Patient Status (New vs. Established)
- Content of Service
- Service Qualifying for a Separate Professional Fee in Addition to an Office/Outpatient Visit
- Qualifications for Individual Consideration of Unusual Office/Outpatient Visit Charges
- Outpatient Consultations
- Telemedicine
- Additional Policy Clarification

- Office/outpatient visits provided on the same day as a hospital admission are considered content of the admission. (See In-Hospital Medical [Non-Surgical] Care Policy Memo No. 5.)
- BCBSKS allows only one Evaluation and Management service per day per member by the same provider.
- Contracting providers agree to assume the responsibility for filing covered office calls when there is payment for a portion of the service.
- Observation care (23-hour observation) is allowed for unscheduled medical care. It is not intended for pre and postoperative care of the surgical patient. Only one observation service is allowed unless the 23-hour observation extends into the next calendar day. In this case, a discharge observation would also be allowed. An observation care service is content of service of a hospital admission.
- For new surgical patient visits, see Policy Memo No. 9, Section I., Paragraph C-2.
- If a physician service is routinely provided to hospice patients, it is not separately billable.

No. 3: Outpatient Treatment of Accidental Injuries and Medical Emergencies

- Definitions (Medical Emergency / Accidental Injury)
- Content of Service
- Critical Care Services
- How to Bill for Treatment of Accidental Injuries and Medical Emergencies in a Hospital Emergency Department
- Additional Policy Clarification

No. 4: Quality of Care

- Quality Improvement Program
- Member Satisfaction Survey
- Disease Management and Wellness
- Health Insurance Portability and Accountability Act (HIPAA)
- State Health Information Exchange (HIE)
- Quality Reporting and Transparency
- Credentialing

No. 5: In-Hospital Medical (Non-Surgical) Care

- Definitions (Medical Emergency / Accidental Injury)
- Content of Service
- Critical Care Services
- How to Bill for Treatment of Accidental Injuries and Medical Emergencies in a Hospital Emergency Department
- Additional Policy Clarification

No. 6: Concurrent Professional Care

- Quality Improvement Program
- Member Satisfaction Survey

- Disease Management
- Health Insurance Portability and Accountability Act (HIPAA)
- State Health Information Exchange (HIE)
- Quality Reporting and Transparency
- Credentialing

No. 7: Radiology and Pathology

- Diagnostic Radiology Policy
- Therapeutic Radiology Policy
- Pathology

No. 8: Obstetrical Services

- OB Services — Non Surgical Content of Service
- OB Services — Surgical Content of Service
- Services Qualifying for Additional Fees
- Additional Policy Clarification
- Additional Obstetrical Procedures

No. 9: Surgery

- Global Fee Concept
- Physicians Who Furnish Entire Global Package
- Physicians in Group Practice
- Providers Furnishing Less than the Full Global Package
- Date(s) of Service
- Reimbursement
- Unusual Circumstances
- Discharge Procedures by Someone Other than the Surgeon
- Additional Policy Clarification
- Adverse Events

No. 10: Assistant Surgery

- Medical Necessity Guidelines
- Reimbursement
- Preoperative and Postoperative Care
- Non-Physician Assistants

No. 11: Multiple Surgical Procedures

- Multiple Surgical Procedures when Performed by One Provider
- Endoscopies, Arthroscopies, and other Scope Procedures
- Other Policy Provisions

No. 12: Anesthesia

- Description
- Time of Administration
- Content of Services within Usual Anesthesia Fee
- Surgical Procedures and Nerve Blocks Performed by the Same Anesthesia Provider
- Method of Determining the Maximum Allowable Payment (MAP)
- Related Policies



Provider Information

Provider Information

This section addresses how to handle things like adding or terminating a provider in your group; maintaining information specific to your provider or practice; change in tax ID; and issues involving your license. Forms are located under

<https://www.bcbsks.com/providers/professional/forms>.

Adding New Providers

Provider Network Enrollment Request — When a new provider is being added to an existing group, we would encourage you to complete the Provider Network Enrollment Request at least 60 days before their start date. Credentialing a provider may take up to sixty days to complete and we cannot backdate the effective date.

<https://www.bcbsks.com/documents/provider-network-enrollment-request-15-481-2021-10-20>.

BCBSKS credentialing program — is comprehensive to ensure that its applicants meet the standards of professional licensure and certification. The process enables BCBSKS to recruit and retain a quality network of applicants to serve its members and ensure ongoing access to care. For more information pertaining to the credentialing program, follow this link:

<https://www.bcbsks.com/providers/professional/publications/credentialing-information>

Terminating a Provider or Changing Address Information

When needing to notify BCBSKS of a provider leaving your group or if you change an address, you will need to complete the <https://www.bcbsks.com/documents/provider-information-change-form-15-141>.

Maintaining Information on the Provider Portal

To complete BCBSKS provider attestation, take the following actions:

1. Sign into Availity
2. Select the Payer Spaces heading
3. Select Blue Cross Blue Shield of Kansas
4. Select the BCBSKS Provider Secure Section (BlueAccess) link
5. Select the name/NPI for your organization
6. Select the Provider Information heading
7. Select the tab labeled Provider Information Forms
8. Review the group
9. Complete the necessary information
10. Select Submit as the group
11. Review each individual provider
12. Complete the necessary information on individual providers
13. Select Submit on individual providers

Business Associate Agreement (BAA)

Any arrangement where another entity, defined here as a *business partner*, is performing services on your (the contracting provider's) behalf that involves the use, transmission, or disclosure of protected health information (PHI) or personal identifying information (PII).

Protecting PHI is a top priority at BCBSKS. By providing us with the names of your business partners, BCBSKS can validate the caller when an inquiry is received. This allows us to safely respond to the inquiry without delaying service to your practice.

To report a business arrangement or to attest to not having any current business arrangements, please follow the path below:

1. Sign into Availity
2. Select the Payer Spaces heading
3. Select Blue Cross Blue Shield of Kansas
4. Select the BCBSKS Provider Secure Section (BlueAccess) link
5. Select the name/NPI for your organization
6. Select the Provider Information heading
7. Select BAA
8. Complete the necessary information
9. Select Submit

Electronic Fund Transfer (EFT)

Upon enrollment with BCBSKS network providers will be required to sign up for EFT payment.

How to sign up for EFT for established clinics:

- Login to Availity
- Select Payer Space
- Select Blue Cross Blue Shield of Kansas
- Select BCBSKS Provider Secure Section (Blue Access)
- Select organization from drop down menu
- Select submit
- Select NPI/Billing Organization Selection from drop-down menu, if needed with multiple clinics.
- Select submit, if needed.
- Select Resources

- Select Form, Publication, and Procedures
- Select EFT
- Complete EFT
- Select submit



Products/Marketplace

Products/Marketplace

This section provides an overview of the Kansas Provider Networks and the Kansas products sold on and off the Health Insurance Marketplace.

EPO

BCBSKS offers a BlueCare Exclusive Provider Organization (EPO) product.

The EPO does not have benefits for services received outside of the BCBSKS service area, with the exception of emergencies or services not provided within the service area. The service area includes 103 Kansas counties, excluding Johnson and Wyandotte.

Members seeking out-of-plan-area services need to contact Customer Service to determine coverage. An out-of-plan-area emergency service or an inpatient admission within 24 hours of the emergency service shall be covered. For special consideration, please use the Solutions referral form at the following link: <https://www.bcbsks.com/documents/request-receive-service-outside-solutions-network-15-504>

When a contracting provider uses a non-contracting provider (either in or out-of-state) to perform a portion of a professional service (e.g., professional component, technical component or other technology utilized in the performance of a service), the contracting provider must bill BCBSKS for all services. If the non-contracting provider bills the member or BCBSKS, the contracting provider will be required to hold the member harmless. However, in the event members request referrals to non-contracting providers, providers should have patients sign a statement acknowledging full understanding of the non-contracting referral and the patient's financial responsibilities. The statement should be filed in the patient's chart.

Self-funded groups or ASO groups

Self-funded groups contract with BCBSKS to provide administrative functions including provider networks, pricing agreements, and claims processing. Oftentimes, these groups define their own benefits and coverage limitations. Two of the largest groups in our service area include the State of Kansas (SOK) employees and the Federal Employee Program (FEP). Links which provide benefit information are included for your use:

- <http://www.bcbsks.com/CustomerService/Members/State/>
- <https://www.fepblue.org/>

Network Pricing Groups

Network Pricing Groups are groups that lease the Blue Cross and Blue Shield of Kansas (BCBSKS) provider network.

BCBSKS has an agreement with the following groups to lease the BCBSKS provider network:

- Kansas Building Trade

The following are guidelines for identifying and handling claims for members of Network Pricing Groups:

- The identification card for Network Pricing Groups will indicate the CAP logo.

- All claims should be submitted to BCBSKS electronically.
 - Enter Member ID as it appears on the KBT/KBTHW or IBEW card
 - 2000B SBR03 Group Number must + KBT/KBTHW or IBEW
 - 2000B SBR09 Claim Filing Indicator+BL
- BCBSKS will price the claim according to the CAP contracting provider network and forward it on to the Network Pricing Group for finalization.
- The Network Pricing Group (not BCBSKS) will finalize the claim and report the claim processing information, including payment, directly to the CAP provider.
- The Network Pricing Group (not BCBSKS) should be contacted with all requests for benefit/eligibility information, customer service assistance, or pre-admission certification. The backside of the identification card indicates the telephone numbers providers should use.
- Claim status and eligibility information about Network Pricing Groups is not available on the [Availity](#) or [BCBSKS](#) websites.

Marketplace products

The Patient Protection and Affordable Care Act (ACA) of 2010 provided the establishment of health insurance exchanges in each state. BCBSKS participates on the federally facilitated exchange, which is also known as the Marketplace. The purpose of the Marketplace, or exchange, is to allow individual consumers to purchase qualified coverage during an open enrollment period. Small business owners are able to purchase coverage for their employees through the Small Business Health Options Program (SHOP), which is open year round. Insurance companies selling products in the Marketplace must have achieved health plan accreditation through an approved accrediting entity. BCBSKS chose URAC as our accrediting organization. In addition, BCBSKS received Qualified Health Plan status from the U.S. Department of Health and Human Services, which is the gold seal approval to sell health insurance products on the Marketplace. An individual can enroll on the marketplace by going to www.healthcare.gov. Participation in the Marketplace has created some new functions described below.

1. Individual Grace Period: The ACA mandates a three-month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. BCBSKS will pend claims received in second and third month of the grace period when payment has not been received. Providers will be notified by letter when a member's claims have been pended for non-payment of premium. When premium payment is received the pended claims will be processed. In the event of non-payment of premiums, the pended claims will be denied as no coverage and the provider will be notified on their remittance advice. During the three-month grace period, provider may not bill the member for anything other than unmet deductibles, copays or coinsurance. After the three-month grace period and notice from BCBSKS through the remittance advice that coverage has been canceled, the provider may bill the member for the services not paid during the second and third month of the grace period. The ACA grace period also applies to policies bought on the SHOP for small groups. However, the ACA grace period for

members of a SHOP policy is only 31 days, rather than 90 days. BCBSKS will suspend claims during this 31-day grace period.

2. Risk Adjustment: The ACA created a guarantee issue environment for the individual and small group markets. The ACA incorporated a process called commercial risk adjustment designed to encourage issuers to compete on premium, efficiency and quality. An issuer's risk adjustment is calculated based on the average of each member's risk scores (estimate of a person's anticipated health care costs). The government will monitor which issuers have low-risk enrolled populations and those with high-risk enrollment. Based on the issuer's risk score, there will be a shift of funds from low-risk to high-risk issuers to offset the cost of care for the high-risk population insured by the issuer with the high-risk score.

The risk adjustment scores for those insured, as well as issuers, and the shifting of funds needs to be managed in a manner that is fair and equitable to all. The risk scores calculated by the issuer for each of its members is based on the member's age/gender, plan selection and ICD diagnosis codes submitted on the claim or extracted directly from the medical record. The risk adjustment calculations are based on claims data in a current year. Diagnosis coding is the primary indicator for risk adjustment calculation and auditing. When a claim record does not equal the clinical reality of the patient's overall health, this creates a gap in risk score calculations. Diagnosis specificity is critical for an issuer to manage its risk adjustment score.

3. Inovalon: The U.S. Department of Health and Human Services requires issuers to conduct risk adjustment audits annually 200 members. The audit requires the issuer to substantiate the diagnosis codes in the claims records by review of the actual medical documentation and identify any medical conditions that can be coded in addition to the codes on the claim. When additional diagnosis codes are identified in a record, these will be noted and reported to the issuer. The issuer will review and determine the appropriate risk adjustments based on the additional codes. Inovalon has been selected to gather medical records on behalf of BCBSKS for other Blue Cross and/or Blue Shield companies. Inovalon is an experienced health care analytics and services company and best-in-class supplier. All pertinent and complete medical records must be provided or made available by the contracting provider at no cost (in accordance with the CAP agreement). BCBSKS selected Change Healthcare as the auditor for the Risk Adjustment Data Validation audit, an annual audit conducted as part of the ACA requirements.



Medicare Advantage

Medicare Advantage

Blue Medicare Advantage (Blue MA) is an authorized Medicare Advantage Organization that contracts with the Centers for Medicare and Medicaid Services (CMS) to offer Medicare Advantage (Part C) and Part D prescription drug insurance plans in the senior market. Information regarding Medicare Advantage can be found on our website, <https://www.bcbsks.com/providers/medicare-advantage>.

Professional Relations Medicare Advantage Contact Information

Topeka

Patrick Artzer, 800-432-0216 ext. 6289, 785-261-6289, Patrick.artzer@bcbsks.com



Member ID Cards

How to Read a Member ID Card

When Blue Plan members arrive at your office, remember to ask to see their current ID card at each visit. This will help you to identify the product the member has, to obtain health plan contact information and to assist with claims processing. Remember, ID cards are for identification purposes only and do not guarantee eligibility or payment of your claim. You should always verify patient eligibility by using Availity or calling the appropriate customer service center.

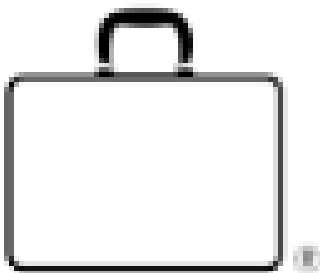
The majority of Blue branded ID cards display a three-character alpha prefix. However, there are some exceptions to this such as stand-alone vision and pharmacy when delivered through an intermediary model, stand-alone dental Program (FEP) that has the letter “R” in front of the ID number. In these situations, please follow the instructions listed on the card to verify eligibility, submit claims and who to contact with questions.

The alpha prefix is critical for any inquiries regarding the member, including eligibility and benefits and is necessary for proper claim filing. When filing the claim, always enter the ID number exactly as it appears on the card, including the alpha prefix. If there is no alpha prefix on the card, never create one. It may cause delays in the handling of your inquiry and claim. In this situation, please follow the instructions listed on the back of the ID card for inquiries and claim handling.

There are various logos that may be displayed on the member ID card for Blue Cross and/or Blue Shield Plans in the US and for international Licensees licensed through the Blue Cross and Blue Shield Association. Member ID cards may include one of several logos identifying the type of coverage the member has and/or indicating the provider’s reimbursement level.

Blank (empty) Suitcase

A blank (empty) suitcase logo on the front of the ID card signifies that the member has coverage that is not a PPO product. Benefit products that display a blank (empty) suitcase logo on the ID cards include:



- Traditional
- POS (Point of Service)
- Limited benefits products — These products typically have higher out of pocket expenses for services provided outside the network.

It is critically important to check the member’s benefits when their suitcase is blank (empty) to avoid additional cost to the member.

PPO in a Suitcase

When you see the “PPO in a suitcase” logo on the front of the member’s ID card, it means that the member has PPO or EPO type benefits available for medical services received within or outside of the United States. It also means that the provider will be reimbursed for covered services in accordance with the provider’s PPO contract with the local plan. The CAP network is the network used for these products.

PPOB in a Suitcase

When you see the “PPOB in a suitcase” logo on the front of the member’s ID card, it means the member has selected a PPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic. The CAP network is the network used for these products.

No Suitcase

Some Blue ID cards do not have any suitcase logos on them. This includes the ID cards for the BlueCare EPO, Medicaid, State Children’s Health Insurance Programs (SCHIP) administered as part of a state’s Medicaid program, Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products.

While BCBSKS routes all of these claims for out-of-area members to the appropriate plan, most of the Medicare complementary or Medigap claims are sent directly from the Medicare intermediary to the member’s Blue Plan via the established electronic Medicare crossover process.

Typically, copays, and deductibles are listed on the front of the ID card along with symbols or product names that indicate additional coverage such as Dental or Prescription drug benefits. The back of the ID card contains additional important information such as prior authorization requirements for inpatient care and mental health services, customer service contact information, and other information designated by the issuer.



BlueCard

BlueCard

The BlueCard program is a system that serves Blue Cross Blue Shield (BCBS) members worldwide. It equips providers with one source (the host plan) for claims submission for patients from other Blue Plans. This term is used when dealing with members whose insurance is issued by an out-of-state plan. With the BlueCard Program comes different terminology.

Home Plan — The BCBS Plan where the patient's policy was issued.

Host Plan — The BCBS Plan where the services are rendered.

As a provider in the BlueCard network, the following applies:

- You are considered a BlueCard PPO (Preferred Provider Organization) provider.
- For out-of-state BCBS members, the identification card will have a suitcase logo located in the right-hand corner to signify the BlueCard.
- Eligibility for BlueCard members can be verified through [Availity.com](https://www.availity.com) or by calling (800) 676-BLUE [2583].
- Submit all claims to the Host plan unless you have a direct contract with the member's Home Plan.
- BCBSKS pricing is followed for services to BlueCard members.
- The Home Plan will confirm benefits and determine coverage based on their medical policy.
- For services that require pre-certification, check the number on the back of the member's identification card.
- The Host Plan is the first point of contact for claim inquiries.
- To verify the status of a BlueCard claim, use [Availity.com](https://www.availity.com) or call: (800) 432-3990 ext. 4058 or (785) 291-4058.



Claims Filing

Claims Filing

- **1500 Claim Form** — The CMS 1500 Claim Form is a universal claim form used by the government and commercial insurance companies. The CMS 1500 is the designated format to submit paper claims to BCBSKS. Go to <https://www.bcbsks.com/providers/professional/education> for a tutorial of the CMS 1500 Claim Form.
- **Electronic Options** — BCBSKS encourages the submission of claims electronically using the ANSI ASC X12N 837 Health Care Claims transactions. For more information on electronic claim options or attachments, please visit: <https://www.ask-edi.com/>.
- **Use of Non-Contracting Providers** — Providers that utilize outside vendors to provide services (i.e. sending blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) should utilize in-network participating ancillary providers to reduce the possibility of additional member liability for covered benefits. A list of in-network participating providers can be found on bcbsks.com under Find a Doctor/Hospital. [Policy Memo No. 1](#), Section XIV states that when a contracting provider uses a non-contracting provider to perform a portion of a professional service, the contracting provider must bill BCBSKS for all services. If the non-contracting provider bills the member or BCBSKS, the contracting provider will be required to hold the member harmless. However, in the event members request referrals to non-contracting providers, providers should have patients sign a statement acknowledging full understanding of the non-contracting referral and the patient's financial responsibilities. The statement should be filed in the patient's chart.
- **Jurisdiction Rules** — Typically, all services provided in the BCBSKS service area (State of Kansas excluding Johnson and Wyandotte counties) should be filed to BCBSKS. There are some exceptions for BlueCard members which is addressed in Section 5. In addition, there are special rules for the ancillary providers outlined on page 6-2.

Corrected Claim vs. New Claim

Corrected claims are considered the retrospective review.

Per Policy Memo No. 1, "a request made from a contracting provider to change a claim (e.g. changing information on the service line, modifier addition, diagnosis correction, etc.) that has previously processed is considered a corrected claim."

Claims denied requesting additional information (e.g. by letter or denial code MA130) never should be marked "corrected claim" when resubmitted. Instead, providers should submit a new claim with the requested information.

The key element is a corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional changes, different procedure code or

diagnosis codes, or any information that would change the way the claim originally processed.

In addition, if a claim comes into BCBSKS with a cover letter or medical records, it is a retrospective review and not a "corrected claim."

Submit a new claim with a "7" indicator for a corrected claim. To void a claim use indicator "8". Include the original claim control number in Box 22 of the CMS claim form.

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.

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:

Claims 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.

Remittance Advice rejection codes:

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.

Labs, DME, HIT, Specialty Pharmacy Providers Filing Blue Claims

Provider Type	How to file (required fields)	Where to file	Example
Independent Clinical Laboratory (any type of non hospital based laboratory) Types of Service include, but are not limited to: Blood, urine, samples, analysis, etc.	Referring Provider: <ul style="list-style-type: none"> Field 17B on CMS 1500 Health Insurance Claim Form or Loop 2310A (claim level) on the 837 Professional Electronic Submission or Loop 2420F (line level) on the 837 Professional Electronic Submission 	File the claim to the Plan in whose state the specimen was drawn* *Where the specimen was drawn will be determined by which state the referring provider is located.	Blood is drawn* in lab or office setting located in Kansas . Blood analysis is done in Oklahoma . File to: Blue Cross and Blue Shield of Kansas . *Claims for the analysis of a lab must be filed to the Plan in whose state the specimen was drawn .
Durable/Home Medical Equipment and Supplies (D/HME) Types of Service include but are not limited to: Hospital beds, oxygen tanks, crutches, etc.	Patient's Address: <ul style="list-style-type: none"> Field 5 on CMS 1500 Health Insurance Claim Form or Loop 2010CA on the 837 Professional Electronic Submission Ordering Provider: <ul style="list-style-type: none"> Field 17B on CMS 1500 Health Insurance Claim Form or Loop 2420E (line level) on the 837 Professional Electronic Submission Place of Service: <ul style="list-style-type: none"> Field 24B on the CMS 1500 Health Insurance Claim Form or Loop 2300, CLM05-1 (claim level) on the 837 Professional Electronic Submissions or Loop 2400 SV105 (line level) on the Professional Electronic Submission Service Facility Location Information: <ul style="list-style-type: none"> Field 32 on CMS 1500 Health Insurance Form or Loop 2310C (claim level) on the 837 Professional Electronic Submission 	D/HME: File the claim to the Plan in whose state the equipment was shipped to or purchased in a retail store . HIT: File the claim to the Plan in whose state the drug was shipped to or where HIT was rendered .	Wheelchair is purchased at a retail store in Kansas . File to: Blue Cross and Blue Shield of Kansas. Wheelchair is purchased on the internet from an online retail supplier in Florida and shipped to Kansas . File to: Blue Cross and Blue Shield of Kansas. Wheelchair is purchased at a retail store in Florida and shipped to Kansas . File to: Blue Cross and Blue Shield of Florida . An HIT company in Missouri renders care at a patient's home in Kansas . File to: Blue Cross and Blue Shield of Kansas .
Home Infusion Therapy (HIT) Types of Service include but are not limited to: Administration of intravenous antibiotic, immune globulin fluid, etc., by a home health nurse in home or equivalent setting.			
Specialty Pharmacy Types of Service: Non-routine, biological therapeutics ordered by a health care professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include but are not limited to: injectable, infusion therapies, etc.	Referring Provider: <ul style="list-style-type: none"> Field 17B on CMS 1500 Health Insurance Claim Form or Loop 2310A (claim level) on the 837 Professional Electronic Submission 	File the claim to the Plan whose state the Ordering Physician is located .	Patient is seen by a physician in Kansas who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in Oklahoma where the member lives for six months of the year. File to: Blue Cross and Blue Shield of Kansas .

Note - Not applicable to FEP



Reimbursement Policies

Reimbursement Policies

BCBSKS accepts the American Medical Association's Current Procedural Terminology (AMA-CPT), HealthCare Common Procedure Coding System (HCPCS) and International Classifications of Diseases 10th Edition (ICD-10-CM) for claims filing.

It is important to maintain current resources when coding.

Quarterly changes are made to the AMA-CPT and HCPCS code books. The changes are effective the first date of each quarter (i.e. Jan. 1, April 1, July 1, and Oct. 1). There is no grace period.

The ICD-10 code book has biannual changes. These changes are effective April 1 and Oct. 1 of each year. There is no grace period.

BCBSKS has developed procedure code listings by categories to assist you when filing and posting claims.

Click on the following listings:

[Assistant Surgery Not Medically Necessary \(NMN\) Listing](#) — These codes will be denied as NOT medically necessary. Assistant Surgery will be allowed for those codes marked with an (*) when performed in a physician's office.

Major/Minor/Zero Surgery Codes — BCBSKS follows Medicare's global surgery indicators for minor/major and zero day surgery codes. Pre- and post-operative periods are defined in [Policy Memo No. 9](#).

- [CMS Physician Fee Schedule](#)

Unit Limitations — BCBSKS generally follows Medicare's Medically Unlikely Edits when determining the number of units any given code can be billed on a single date of service.

- [CMS MUE edits](#)

Medical Policies —

- BCBSKS Members — [Medical Policies](#) are available on the BCBSKS website and can be searched by procedure code or narrative.
- Bluecard Members — Members insured by another plan are not subject to BCBSKS medical policy. Their Home Plan will determine coverage and medical necessity. You can link to the members Home Plan medical policy by using the policy router found on the BCBSKS medical policy website page and entering the first three letters on the ID card.

Preventive Services Quick Reference Guide — This brochure identifies the health care reform preventive health benefits with recommended CPT and diagnosis codes. The Preventive Services Quick Reference Guide can be found on our [website](#).

Limited Patient Waiver — Services that do not meet medical necessity criteria or deemed experimental or investigational or exceed utilization limits should be discussed with the patient in advance and a signed waiver should be obtained. Patient-requested services may also warrant a Limited Patient Waiver. The waiver form must be: Signed before receipt of

the service, be patient-, services-, and reason-specific; Date-of-service and dollar-amount specific; Retained in the patient's file; and acknowledged by the patient that he or she will be personally responsible for the amount of the charge, to include an approximate amount of the charge at issue. If the waiver is not signed before the service is provided, then the service is considered a provider write-off, unless there are extenuating circumstances. If a waiver has been obtained in advance of the service, you can communicate this with BCBSKS by adding modifier GA to the service in question at the time of claims filing.

The waiver form has been updated to include a second option which allows the patient to receive the service and waive their right to have the claim filed to BCBSKS.

The waiver should be presented on an individual basis to the patient. A blanket statement signed by all patients is not allowed. The waiver cannot be utilized for services considered to be content of another service.

BCBSKS-Specific Edits

Diagnosis Coding —

- Code to the highest level of specificity including laterality.
- A non-specific code may be used when it is the only option.

Accident Diagnosis — Use in primary position

*Modifiers —

- Modifiers for Telehealth
 - Modifier 02 – Patient not at home
 - Modifier 10 – Patient is at Home
- Modifier 22 – claim submitted on paper with records attached indicates the claim needs to be reviewed by medical review
- Modifier 25 –
 - Use only for established patient's E/M codes (not new patient E/M).
 - E/M reimbursement is reduced by 25% MAP.
 - Do not use when billing 96372 (therapeutic injection) or a service that does not have a global period.
- Modifier 59 – Payor Specific Edit
 - Recognized only for CPT codes of Lesion Removal (10000's) or Radiology (70000's).
 - Not recognized like Medicare.
- Modifier GA –patient wavier on file.
 - NOTE: A waiver cannot be used to collect the difference between the provider's charge and the allowed amount on a given covered service, nor can it be used for services that are content to another service provided. However, if the member requests a deluxe item or requests higher end services that may be otherwise covered at a basic level, a waiver can be used to collect the difference between the allowance for the basic service and the charge. [Limited Patient Waiver](#)

- Modifier GT – telehealth claims
- Modifier Q6 – Locum Tenans

Age Recognition —

- Children 11 years and younger
- Adults 12 years and older

Quality-Based Reimbursement Program (QBRP)

The Quality-Based Reimbursement Program (QBRP) is designed to promote efficient administration, improved quality, and better patient care and outcomes. Contracting providers have an opportunity to earn additional revenue through add-ons to allowances for meeting the defined quality metrics. BCBSKS claims data is used to determine qualification for any applicable metric requiring data.

For more information regarding QBRP and the requirements to be met for additional reimbursement, see pages 8-18 of the [2023 Professional Relations CAP Report](#).



Specialty Guidelines

Specialty Guidelines

The following Specialty Guidelines can be found on our website,
<https://www.bcbsks.com/providers/professional/publications/manuals>.

- Ambulance
- Autism Guidelines
- Behavioral Health
- Durable Medical Equipment/Home Medical Equipment
- Health Department Billing Guidelines
- Home Infusion Therapy
- Physical Medicine (Chiropractic, Physical Therapy, and Occupational Therapy)
- Substance Abuse
- Vision & Ocular Services



Other Party Liability

Other Party Liability

What is OPL?

Other Party Liability (OPL) is the department within BCBSKS which determines whether services are eligible for coverage under another insurer. OPL then assigns primary liability with the correct carrier.

Annually, BCBSKS verifies whether or not our members and/or their dependents have other health insurance coverage. OPL also verifies if injuries and other certain conditions are eligible to be covered by worker's compensation or auto insurance.

This activity helps contain costs that affect rates paid by our members. OPL deals specifically with duplicate coverage (not Medicare or Medicaid), worker's compensation and no-fault auto.

Submitting a Claim

When the member is covered under two different insurance carriers, a claim should be filed with both carriers, except when two BCBSKS policies are involved (BCBSKS will coordinate these for you with one filing). The claim filed to each policy should include information regarding the other carrier.

When an Explanation of Benefits (EOB) is received from the first or primary carrier, it should be sent to the secondary carrier's OPL department. It should NOT be refiled with another claim form. This could cause the EOB to be misdirected, possibly resulting in a denial for submitting a duplicate claim. The same procedure applies to denial letters. In all cases, be sure to include the member's ID number for the carrier to which you are sending the information.

Timely Filing

The reason for filing a claim with each carrier is to protect providers from the possibility of receiving a timely filing denial. An example of such a case would be when a worker who has been injured on the job seeks treatment and advises the provider that claims will be paid by the worker's compensation. Later, if the condition is found to be unrelated to the patient's employment, a denial could be received from the worker's compensation carrier or refunds could be requested on claims for which they have already paid.

If this takes place more than 15 months from the date of service, those claims which would have been eligible under the patient's BCBSKS policy by filing in a timely manner will be denied. Denials for not filing within the specified time period are a provider write-off. If those same claims been filed with BCBSKS originally, BCBSKS would have denied services as work related, but would reprocess them for eligible benefits upon receipt of the denial letter.

BlueCard

Providers should file a secondary Host* Inter-Plan Teleprocessing Services (ITS) claim to BCBSKS just as you would a claim for any Kansas Plan member. However, if the patient is covered under another Blue Plan membership and a BCBSKS Plan membership, a separate claim will need to be filed under each ID number. Inquiries regarding over payments on claims paid by BCBSKS as the Host Plan that have resulted from payment

made by another carrier should be directed to our Customer Service Center at (785) 291-4058. Do not direct these inquiries to the OPL department.

*Host is defined as a BCBSKS contracting facility/provider rendering services for a member of another Blue Plan.

Avoiding Delays

When investigation by OPL is necessary, it may delay the processing of your claims. To avoid this delay, you may choose to provide OPL with the information before or at the time of filing your claim. Providers may want to review the [OPL form](#) with patients fill out the questionnaire before receiving services. A form for providers to request a deduction of OPL related over payments is also available. Both the [OPL Questionnaire](#) and the [OPL Deduct Authorization](#) form can be found on the BCBSKS website at: <https://www.bcbsks.com/providers/professional/forms>.

Send or fax completed forms to the BCBSKS OPL department to:

Blue Cross and Blue Shield of Kansas
Attn: OPL cc217
1133 SW Topeka Blvd
Topeka, KS 66629-0001
Fax: (785) 291-0771

Reconciling your Account

To reconcile your patient's account after the secondary carrier has processed a claim, refer to the primary carrier's EOB, as well as the secondary carrier. The following rules apply for provider reimbursement and when reconciling the patient account:

- If patient is not an FEP member or when the provider contracts with the primary carrier, the provider should accept the primary carrier's write-off. Then, determine the patient's responsibility by subtracting that provider write-off and the payments of the primary and secondary carriers from the total charge(s).
- If patient is an FEP member or when the provider does not contract with the primary carrier, the provider can determine the provider write-off by subtracting the lesser allowance of any carrier with whom the provider has a contracting arrangement from the total charge. Determine the patient's responsibility by subtracting the provider write-off and the payments of the primary and secondary carriers from the total charge(s).
- If the patient's responsibility, after the primary carrier's payment, is greater than the BCBSKS allowance, then the provider must accept the BCBSKS write-off.
- If the provider does not have a contracting agreement with the primary carrier, but does contract with BCBSKS, then the BCBSKS allowance will be enforced.
- If the provider has a contracting agreement with both carriers and the patient's remaining balance, after the primary carrier's payment, is equal to or less than the BCBSKS total allowance, then the primary write-off is imposed.

- If the provider has a contracting agreement with both carriers and the patient's remaining balance, after the primary carrier's payment, is greater than the BCBSKS total allowance, then the BCBSKS write-off is imposed.
- Remittance advice code list can be found at <https://x12.org/codes>.

The BCBSKS Remittance Advice (RA) for secondary payments will show the amount paid on the secondary claim, the amount paid by the primary carrier, the amount of patient responsibility, and the total provider write-off after taking into consideration the benefits of both carriers. This eliminates the need to retrieve the primary carrier EOB for balancing patient accounts. Listed below are specific coding combinations on the RA that helps the provider to identify a claim involving OPL.

OPL Code(s) on RA	Coding Details
ARC = 23	Paid as secondary carrier
ARC = 227 (16 for FEP) RMK = N179	Awaiting a response to an OPL questionnaire sent to the patient.
ARC = 22, RMK = MA04	The primary carrier must process first and an EOB for the primary carrier is required or the EOB from the primary carrier does not match this claim.
ARC = 23, RMK = M43	The primary carrier's payment exceeds the amount payable under the patient's contract. No secondary payment is available.
ARC = 19, RMK = MA04	The service is because of a job-related illness or injury (Workman's Compensation Applies).
ARC = 21, RMK = MA04	The service is because of a motor vehicle-related accident (Automobile Insurance Applies).
ARC = 23, RMK = MA04	The patient has accepted a financial settlement from another insurance carrier for this claim.

Duplicate Coverage

OPL coordinates benefits with other policies by following the portions of the National Association of Insurance Commissioners (NAIC) Coordination of Benefits Model Regulation adopted by the State of Kansas, (K.A.R. 40-4-34) and regulated by the Kansas Insurance Department (KID).

Coordination of Benefits (COB)

When payments for the same claim through multiple health insurance companies exceed the total charge (or allowance if the provider is contracting), then benefits as secondary are reduced. The difference between what BCBSKS would have paid as primary and what we actually pay as secondary is the COB savings.

All local contracts, Administrative Services Only (ASO) self-insured groups and out-of-area groups, who elect to do so, apply these COB savings to an accumulator within our claims system for that patient. Savings in the accumulator may later be used when our payment as secondary combined with the primary payment is insufficient to meet the allowable expense.

When appropriate, the claims system automatically draws any available savings to the point of exhausting savings or paying the amount for which the patient would have been responsible for otherwise, whichever occurs first. The process of adding to and borrowing from this accumulator is referred to as a 'Benefit Reserve' and is applied to claims within the same benefit year.

BCBSKS does not coordinate benefits with active Military such as Champus, Tricare, and Triwest. However, BCBSKS does coordinate benefits with the Veterans Administration if the EOB is attached to the claim or electronically submitted.

When OPL is involved, the provider does not have to take the contractual write off of both the primary payor and BCBSKS. The providers should apply the greater write off of the two.

If the facility submits an Auto Deduct form and the payors don't coordinate, OPL would send a letter to the facility indicating the payors do not coordinate benefits. When payors do not coordinate benefits, the over payment should be refunded to the member.

Maintenance of Benefits (MOB)

ASO and out-of-area groups may choose to apply MOB to dual coverage, rather than the standard COB regulated by the National Association of Insurance Commissioners (NAIC) and State Model. MOB does not apply the Benefit Reserve, nor does it ever allow the combined payments of carriers to exceed the allowable charge regardless of the provider's contracting status. In some instances, the group has elected to hold the combined payments to the amount payable by their policy as if they are the only insurance coverage available.

Groups currently using MOB include Great Plains Manufacturing Dental and RX only, and FEP.

Rules in Determining Primary Carrier with Duplicate Coverage

At times, BCBSKS receives inquiries asking us which policy is the primary carrier for a patient and how we determine that information. The NAIC and State Models have set guidelines referred to as Order of Benefit Determination to help us determine where the primary payment responsibility lies when duplicate coverage exists. The most frequently used are:

Subscriber Rule — When a patient is covered as the subscriber of one health insurance plan and that same patient is covered as a spouse or dependent under another health insurance plan, the plan covering the patient as the subscriber will be the primary carrier.

Birthday Rule — When each parent covers the children on his/her own health insurance plan, then the parent who has a birthday occurring first in the year is primary for the children. For example, if the mother's birthday is in February and the father's birthday is in June, then the mother's plan becomes primary for the children because of her birthday

occurring earlier in the year than the father's birthday. The age (year of birth) of each parent is not a factor.

Divorce (Legal Separation) Rules — If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage, then that parent's plan is primary. If the decree does not establish primary carrier, the parent with legal (not residential) custody will be primary. In the case of joint custody, the Birthday Rule is applied. In the case of remarriage, the benefits of the stepparent married to the primary natural parent will be determined before those of the other natural parent.

Retiree (or laid-off) Rule — When the employee is insured on two health contracts and one contract covers the person as a retired or laid-off employee and the other covers the person as an active employee, then the contract covering the person as an active employee will be considered primary. This rule will only be applied if both contracts follow the retiree/laid-off employee rule.

Consolidation Omnibus Budget Reconciliation Act of 1985 (COBRA) Rule — A group providing continuous coverage as a COBRA policy will be deemed secondary to another covering that person as an active employee. As with the Retiree Rule, the insured must be the same on both policies.

Death resulting in remarriage Rule — The health plan for the natural parent is primary for the children and the plan of the stepparent is secondary.

Dumping Rule — When one policy does not contain a non-duplication of benefits clause, then that contract automatically becomes the primary carrier.

Athletic Rule — When one plan is a school athletic coverage only plan and the patient is covered under another health plan, then the other health plan will automatically become the primary carrier for that patient.

Birthmother Rule — If a birthmother has coverage separate from the adopting parents, the birthmother's coverage will be considered primary. If the adopting parents have two family memberships, normal COB rules and regulations will apply.

Adoptions Rule — If the birthmother has coverage which extends to the child and because of the mandate for coverage of adopted children, then the child is also covered under the adopting parents' coverage. Primary coverage will be determined by which group contract has been in effect the longest.

Single mother with newborn Rule — Follow regular National Association of Insurance Commissioners (NAIC) guidelines for determining primary carrier for both the mother and the child.

Extension of Benefits (Senate Bill 23) Rule — When an individual is an inpatient on the date his/her coverage changes from one plan to another, the preceding plan is required to extend coverage for that hospitalization for up to 31 days or the date of discharge, whichever occurs first. This law applies to insurers having a member residing in Kansas. Administrative Services Only (ASO) groups may opt out of applying this law.

Medicare and two group policies Rule — Active employee policies are primary over Medicare policies. Medicare policies are primary over retiree policies. If the patient is covered under Medicare and two policies and one of the policies being a retiree policy, the following would apply:

- Primary — Active employee policy
- Secondary — Medicare policy
- Tertiary — Retiree policy

Where Medicare is for disability other than End Stage Renal Disease (ESRD) and the patient is enrolled in a small group not subject to the Omnibus Budget Reconciliation Act of 1986 (OBRA-86), then Medicare is primary over the group plans.

Longer Shorter Rule — If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time will be considered primary.

Shared Payment (50/50) Rule — If none of the preceding rules determine the primary plan, the allowable expenses shall be shared equally between the plans.

OPL Exclusions

BCBSKS contracts contain an exclusion section which outlines conditions for which benefits will not be provided. Among these exclusions are Worker's Compensation and No-Fault Auto related services. As an exclusion (rather than coordination) of benefits, the payments made by the other insurer cannot be used toward satisfying any shared patient responsibility, such as deductible and coinsurance, imposed by the BCBSKS contract.

As stated previously under Submitting a Claim, it is still important to file with BCBSKS to avoid a timely filing problem in case services are later denied by the carrier first thought to be primary and/or patient responsibility.

- **Worker's Compensation** — Services provided as the result of work-related injury or illness will not be covered by BCBSKS when the patient is covered (or required to be covered) by worker's compensation law. If the patient accepts a settlement giving up the right to future medical services payment, BCBSKS will not pay for services that would have been payable by the worker's compensation carrier except for that settlement. If the worker's compensation program limits benefits because other than specific healthcare providers are used, BCBSKS will not pay balances of charges from such non-specified providers. Self-employed persons and others exempt from the Worker's Compensation Act will not be subject to this exclusion.
- **No-fault Automobile Insurance** — Benefits will not be provided for services resulting from accidental bodily injuries because of a motor vehicle accident to the extent that the services are payable under any medical expense payment provision of any automobile insurance policy. The Kansas Automobile Reparations Act requires motor vehicle liability insurance policies to include Personal Injury Protection (PIP). K.S.A 40-3109 identifies the injuries for which PIP coverage must be provided as injuries sustained in the US or Canada while:

1. entering into a motor vehicle
2. alighting from a motor vehicle

3. in the use of a motor vehicle
4. in the operation of a motor vehicle
5. in the maintenance of a motor vehicle

If the accident falls into one of the above categories, BCBSKS will deny the claims until the charges have been filed with the auto insurance carrier. Benefits will be provided according to the benefits of the BCBSKS contract after BCBSKS has received either a letter of denial from the auto carrier or a complete itemization of PIP payments after those maximum benefits have been exhausted. Services paid for by the auto carrier of the responsible party are not PIP and do not fall within this exclusion. Such payments are liability and fall within the category of subrogation.

Subrogation

Current state insurance laws do not permit routine subrogation in Kansas. Local contracts cannot add this rider. ASO and out-of-area groups, however, have the option of whether or not to attach the Subrogation rider to their contracts. Subrogation is defined as “The substitution of one for another as creditor so that the new creditor succeeds to the former’s rights or obligations.” In short, subrogation is the recovery of payment because of a third party liability. BCBSKS handles those contracts with this rider on a pay and pursue basis. Recoveries and inquiries into and/or regarding subrogation are outsourced by BCBSKS to:

The Rawlings Company
One Eden Parkway
PO Box 49
LaGrange, KY 40031-0049

You may inquire as to whether a group has a subrogation rider through the OPL department.

Multiple Carriers Assuming Primary Payor Responsibility

When there is more than one insurance company, Kansas state law and/or the BCBSKS member contract dictates which insurance carrier has the primary liability, however, there are some cases when State law or member contract is not a factor and more than one insurance company assumes the primary responsibility.

Example — Patient’s BCBSKS contract does not include a subrogation provision that allows for the recovery of payment because of a third party liability.

When one of these (or similar) situations above exist and:

1. BCBSKS is paying on the claim and services were provided by a contracting provider, the provider will be required to accept the BCBSKS MAP as payment in full and hold the member harmless. Money in excess of the contracting provider allowance would belong to the patient/member.
2. BCBSKS does not allow the claim (services are non-covered), the BCBSKS allowance is not applicable. Payment, allowance and write-off issues would be between the other insurance carrier, the provider and the member.



Remittance Advice (RA)

Remittance Advice (RA)

Understanding the RA

The Remittance Advice is a computer generated report that explains the processing of a claim. There is usually more than one claim on an RA and it can list many patients. Providers usually post these entries to their accounts receivable.

The electronic standards for remittance advice have been applied to the paper remit for consistency and to allow more claim adjudication detail fields on the paper remit.

Paper vs. Electronic?

How can you tell whether the claim was processed as a paper claim or electronic claim? When claims are received by BCBSKS, a control number is assigned to the document. The first two digits of the 12-digit number help to identify whether the claim was received in a paper or electronic format. It also can identify if attachments were received with the claim. The third and fourth digit identify the year in which the claim was received. The fifth through seventh digit identifies the Julian date or number of days in the year that it was received. The remaining digits represent the sequence in which the claim was received/controlled on the date the control number was assigned. Occasionally, there will be a suffix added to the claim which indicates that an adjustment was completed.

The claim number is reported to you in the left-hand column of the Remittance Advice below the individual patient name.

Claims beginning with 20 indicate they were received in paper form. Claims beginning with 38 indicate they were received in paper form with attachments such as medical records. Claims beginning with 25 and 57 indicate they were received in an electronic (paperless) format.

Let's break down a control number for example: 202300500001

20 — The claim came in as a paper claim.

23 — It was received in 2023.

005 — It was received Jan. 5.

00001 — It was the first claim in the sequence.

If you need assistance regarding the format of the RA, see [Professional Provider Report S-05-03](#).

Reason and Remark Codes

In 2003, BCBSKS implemented Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets implementation. These are mandated remark and adjustment reason codes. Lists of these codes with a description are available through X12.org/codes:

[Claim Adjustment Reason Codes \(139\)](#)

[Remittance Advice Remark Codes \(411\)](#)



Quality and Disease Management

Quality and Disease Management

Disease Management/Wellness

The disease management and quality improvement area provides focused disease management services for chronic conditions such as asthma, coronary artery disease, CHF, COPD, diabetes, and hypertension/hyperlipidemia. The primary goal of the programs is to improve the quality of life for BCBSKS members while achieving efficient use of health care services.

Case Management

The case managers are a team of professional registered nurses, certified in case management and experienced in advocating for members with complex medical conditions.

What is case management? Case management offers our members:

- An opportunity to discuss questions about the member's health care needs and benefits.
- Assistance with coordination of care.
- Assistance with identifying situations that involve unusual use of services.
- Evaluation of other available health care options including possible community services.

How does the program work? Referrals are received from multiple sources such as the member, family or caregiver, physician or other health care providers, or employers.

When a referral is received, the member's current needs, medical history and available medical benefits are evaluated.

The case manager provides information to the member on the cost efficient use of benefits, potential alternative use of benefits and/or coordination of existing benefits.

The case manager works with the member/family, physician and other members of the treatment team in the development of a plan.

The case management program is provided as a benefit within the member's health insurance plan. Participation in this program is voluntary.

Examples that may benefit from case management include:

- Complex wound management
- Head injuries and strokes
- High-risk pregnancies
- Multiple trauma
- Palliative and end-of-life care
- Premature/high-risk infants
- Progressive neuromuscular deterioration diseases (ALS, MS, Parkinson's, etc.)
- Severe burns
- Specialty drugs
- Spinal cord injuries
- Transplants
- Ventilator dependency

Clinical Care Coordination

Clinical Care Coordination focus' on connecting members to health care professionals (i.e. Primary Care Physician or PCP) and/or services. The Coordinator's goal is to close clinical care gaps and/ or documentation gaps in health conditions.

The Coordinator is a registered nurse with chronic care professional certification, and health coaching and motivational interviewing skills.

The Coordinator will attempt to arrange the care of members with gaps by communicating with the member's PCP as the first step to facilitate the member's engagement with their PCP.

When necessary, the Coordinator will reach out to the member directly to provide health coaching and support to help initiate the care process for the member to engage with a health care professional or service.



Prescription Drugs

Prescription Drugs

Prior Authorization

Certain drugs required prior authorization based on their policy. BCBSKS provides a link on the BCBSKS website that contains a list of drugs requiring prior authorization:

http://www.bcbsks.com/CustomerService/Providers/MedicalReview/pre-cert_pre-auth.shtml

- [Cover My Meds](#) — BCBSKS encourages you to use Cover My Meds which is an EHR interface that provides a simple, standards-based, single point of integration for EHR systems to work with all payors connected to CoverMyMeds.

Specialty Pharmacy

BCBSKS is proud to introduce you to the Specialty Pharmacy Program. This program benefits members with conditions requiring specialty medications. Specialty medications generally meet one or more of the following characteristics:

- High cost because of treatment of complex conditions
- Self-injected, inhaled or taken orally
- Special handling or storage
- Strict compliance and patient support
- Additional education and support required from a health care professional
- Usually not stocked at retail pharmacies
- May only be available through limited distribution arrangements

Through Accredo Specialty Pharmacy, medications and supplies are delivered to the member or the doctor's office.

To order through Accredo Specialty Pharmacy, call or fax the member's prescription to Accredo Specialty Pharmacy at (833) 721 1620 or fax to (888) 302 1028.

A list of specialty medications is available at the following link:

https://qa.myprime.com/content/dam/prime/memberportal/WebDocs/Other/SpecialtyDMLs/BCBSKS_DML.pdf

K-TRACS

When prescribing and dispensing opioid medications, BCBSKS encourages all prescribing providers to use Kansas Tracking and Reporting of Controlled Substances, or K-TRACS.

K-TRACS is the prescription monitoring program that tracks the use of controlled substances and allows a provider to access a controlled substance report for patients. Through the K-TRACS portal, providers can access what controlled substances a patient has filled, as well as see the quantities, prescribing providers, and pharmacies associated with each prescription.

Issues can be easily identified in-office and addressed at the point of discovery.

The Kansas State Board of Pharmacy, the Kansas Department of Health and Environment, and Aprriss Health have partnered to provide all prescribers and pharmacists in Kansas with access to K-TRACS directly in electronic health records and pharmacy management systems. The project is funded by a grant from the Centers for Disease Control and Prevention.

K-TRACS in use?

Data from K-TRACS shows that more and more providers are registering and using K-TRACS to access the valuable data. Imagine looking up a patient only to find they have visited 15 physicians and filled 15 controlled substance prescriptions in the past 90 days. Would you think twice before providing a controlled substance for a patient who was visiting eight different pharmacies for their 15 controlled substance prescriptions?

K-TRACS helps prescribing providers identify patients who may be misusing or diverting opioids and can help prevent unnecessary opioids from entering these patients' hands.

K-TRACS also helps providers identify patients who may need a referral to a pain management specialist. More importantly, K-TRACS helps identify patients with an unknown opioid-use disorder so these patients can begin receiving help for their addiction. You can access more information about K-TRACS or register for K-TRACS at the Kansas Board of Pharmacy website: <https://pharmacy.ks.gov/k-tracs-responsive/home>

By integrating this tool into practices, providers can help ensure the appropriate use of opioid medications for patients and BCBSKS members.

Addiction or misuse of opioids often starts innocently — after a knee replacement, tooth extraction, or accident — and is not discriminatory in nature.

Opioid addiction can happen to anyone. It is important to keep in mind that each person struggling with opioid use has a unique story, and it is going to take a multi-disciplinary approach to help them.

National Drug Code (NDC)

Submitting an NDC number on a BCBSKS claim use outer packaging for NDC#.

National Drug Code (NDC) Format - The HIPAA 5010 standard NDC format requires 11 digits, even though the FDA only assigns 10 digits. A leading zero must be added to the appropriate segment to bring the total digits to 11. There are three segments: the first segment identifies who packaged the product and will have 4 or 5 digits, the second segment identifies the drug and will have 3 or 4 digits, and the third segment represents the package size and will have 1 or 2 digits. A leading zero must be added to the appropriate segment to bring it to the 5-4-2 HIPAA format. Below are examples to assist with the formatting of the NDC:

- 5555-4444-22 would become 05555-4444-22
- 55555-444-22 would become 55555-0444-22
- 55555-4444-2 would become 55555-4444-02



Important Contact Information

Important Contact Information

Who to Call

Questions Professional Relations will answer:

1. Instruct providers on the correct method of completing a CMS 1500 claim form.
2. Answer questions about CPT, HCPCS and ICD-10 coding.
3. Clarify newsletter information.
4. Answer provider contract, policy and procedure questions.
5. We accept written notice of any changes that affect the provider file.
6. Distribute Charge Comparisons upon provider request.
7. Send out contracting packets to Kansas providers who have recently started practicing, had a status change, or have recently had a tax identification number change.
8. Research provider issues and follow through with provider education when necessary.
9. Initiate provider credentialing activity.

Note — [Click here for a complete list of contact information](#), including Customer Service, OPL, FEP, EDI, and New Directions.

Forms

BCBSKS has a comprehensive list of forms available for you use including: Electronic funds transfer, Other Party Liability questionnaire, Provider change of information, Limited Patient Waiver, and more. For a complete listing of forms, please go to:

<https://www.bcbsks.com/providers/professional/forms>.

Professional Relations contact info

Hays

Jennie Fellers-Morgan, 800-432-0216 ext. 4223, 785-261-9969,
jennie.fellers-morgan@bcbsks.com

Hutchinson

Patrick Romm, 800-432-0216 ext. 4273, 620-663-1313, patrick.romm@bcbsks.com

Topeka

- Heather Schultz, 800-432-0216 ext. 7724, 785-291-7724, heather.schultz@bcbsks.com
- Darin Fieger, 800-432-0216 ext. 8207, 785-291-8207, darin.fieger@bcbsks.com
- Jennifer Falk, 800-432-0216 ext. 8651, 785-291-8651, jennifer.falk@bcbsks.com
- Gwen Nelson, 800-432-0216 ext. 8716, 785-291-8716, gwen.nelson@bcbsks.com
- Provider Network Services, 800-432-3587, 785-291-4135, option 1 or 3,
prof.relations@bcbsks.com

Wichita

- Kyle Abbott, 800-432-0216 ext. 1674, 316-269-1674, kyle.abbott@bcbsks.com
- Vickie Kloxin, 800-432-0216 ext. 1674, 316-269-1674, vickie.kloxin@bcbsks.com



Revisions

Revisions

01/01/2018	Redesigned manual.
01/01/2019	Page 13 – Removed Solutions reference.
	Page 22 – Added Corrected Claim vs. New Claim section.
	Page 47 – Added K-TRACS section.
01/01/2020	Page 6 – Added link to Business Associate and Vendor Offshore Outsourcing Acknowledgement and Attestation forms.
	Page 6 – Added Additional Policy Clarification information.
	Pages 12-13 – Expanded information on ASO Groups. Refined information on Network Pricing Groups.
	Pages 21-22 – Added corrected claims verbiage for clarity.
	Page 26 – Added BCBSKS-specific edits information.
09/14/2020	Page 47- Changed Professional Relations Representative name/contact information from Debra Meisenheimer to Christy Richards
01/01/2021	Page 7 – Updated wording of Policy Memos, No.2 Office/Outpatient Visits section.
	Page 10 – Updated link under Provider Information, Maintaining Information on the Provider Portal.
	Page 10 – Updated/Added wording under Provider Information section.
	Page 15 – Updated wording under Marketplace Products.
	Page 27 – Updated Modifiers under BCBSKS Specific Edits section.
	Page 29 – Added/updated links under Specialty Guidelines section.
	Page 40 – Updated Reason and Remark Codes under Remittance Advice (RA) section.
01/01/2022	Page 11 – Updated Maintaining Information on the Provider Portal with step by step
	Page 12 – Updated Business Associate Agreement (BAA) with step by step
	Page 24 – Added Administration and Immunization Reimbursement section
	Page 32 – Updated link on where to find Specialty Guidelines and removed individual links
	Page 35 – Updated wording under Avoiding delays on OPL information
	Page 36 – Added additional bullet about Remittance advice code list
	Page 47 – Updated Specialty Pharmacy section to Accredo Specialty Pharmacy and their contact information

Continued on next page

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01/01/2022 continued	Page 48 – Removed The Integration Process section
	Page 48 – Added information on National Drug Code (NDC)
	Page 51 – Updated Professional Relations contact information to include Heather Schultz and removed Christy Mugler
03/08/2022	Page 11 – Added EFT section
03/31/2022	Page 23 – Updated Administration and Immunization Reimbursement section to follow CPT Guidelines
	Page 49 – Updated Professional Relations contact information to include Patrick Romm, removed Christy Richards
01/01/2023	Page 5 – Updated CAP section to reflect current practices
	Page 12 – ERT section, added information for established clinics
	Page 14 – Updated steps for completing ERT form
	Page 15 – Updated Network Pricing Groups to reflect accurate groups
	Page 20 – Added Medicare Advantage section
	Page 24 – Updated Claims Filing section to reflect current practices
	Page 27 – Updated Corrected Claim vs. New Claim section
	Page 29 – Updated where to find the Preventive Services Quick Reference Guide
	Page 30 – Updated modifiers to reflect current and accurate modifiers
	Page 33 – Added information on Telehealth modifiers
	Page 37 – Updated table to reflect accurate OPL codes on the RA

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