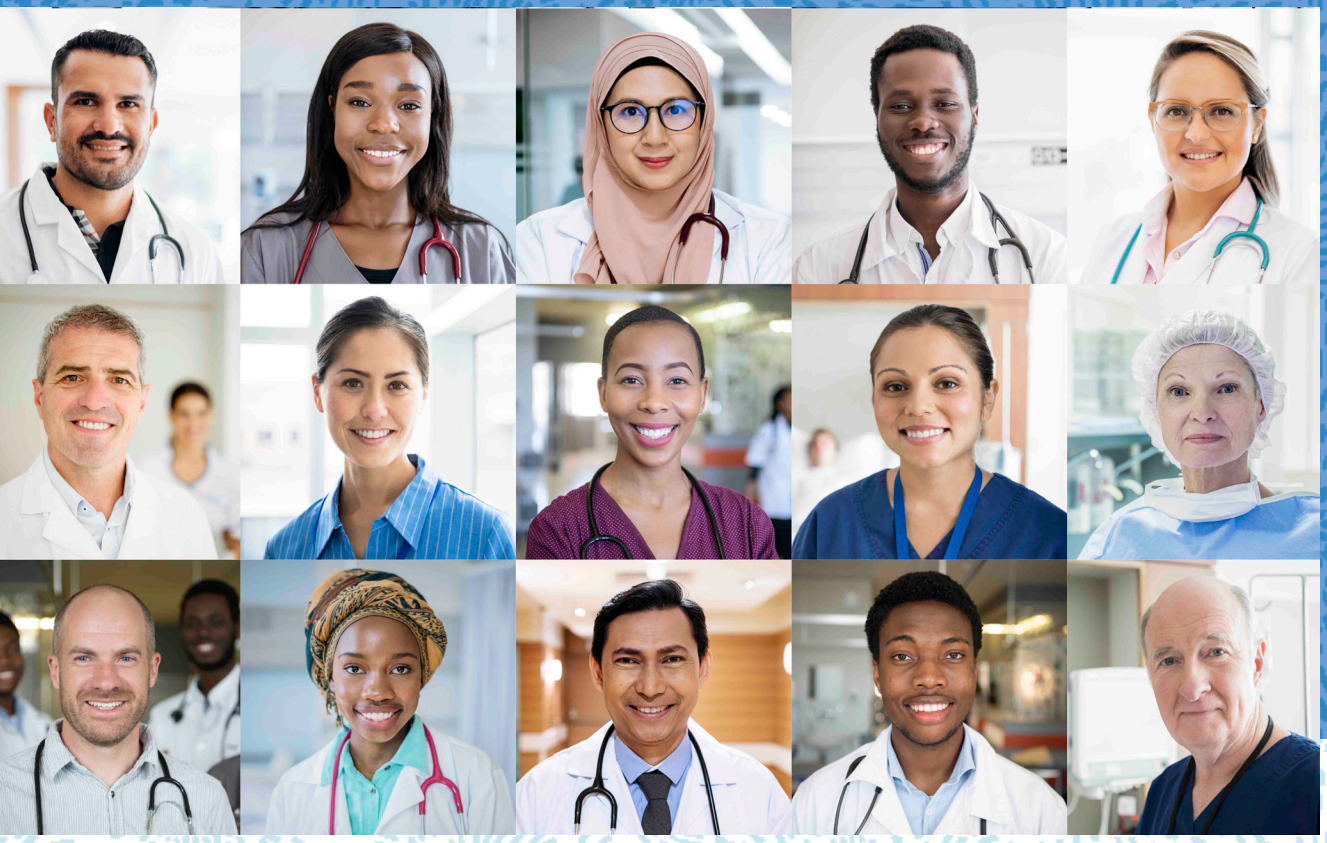
2026 Manual

Professional Provider Manual



BlueCross BlueShield Kansas

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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 provider relations staff member 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.

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 Competitive Allowance Program (CAP) network.

CAP and Policy Memos

Competitive Allowance Program (CAP)

- The 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 published in July which allows the provider time to decide if they wish to remain contracting.

Policy Memos

BCBSKS Policy Memos apply to all contracting providers. 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.

Termination Based on Professional Competence or Conduct

For terminations related to professional competence or conduct, or suspension of participation status due to concerns for member health, welfare or safety, BCBSKS will provide written notice of the intent to terminate within the timeframe specified in the provider contract. The written notice will include:

- An explanation of the reasons for the proposed adverse action
- The provider's right to an in-person hearing
- The right to be represented by legal counsel

The provider has 30 days from the date of the termination notice to notify BCBSKS that they are requesting a hearing. If the provider requests a hearing, the following procedures will apply:

- Written notification of the hearing date will be provided at least 60 calendar days in advance
- The hearing panel will include an actively practicing clinical peer of the practitioner who is not involved in network management
- Written notification of the hearing panel's decision will be provided within 60 calendar days following the closure of the hearing

Provider Information

Provider Information

This section addresses how to add or terminate a provider in your group; maintaining information specific to your provider or practice; change in tax ID; and issues involving your license.

Adding New Providers

Provider Network Application. When a new provider is being added to an existing group, we encourage you to complete the Provider Network Application at least 180 days before their start date. Contracting a provider may take up to 180 days to complete and we cannot backdate the effective date.

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.

Terminating a Provider or Changing Address Information

When a provider leaves your group or if your address changes, please complete the Provider Change of Information form, found on our website www.bcbsks.com.

Maintaining Information on the Provider Portal

To complete the 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 provider.

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.”

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 Request to Receive Service Outside of Solutions Network form.

Self-funded groups or ASO groups

Self-funded groups contract with BCBSKS to provider 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), to include Federal Employee health Benefit (FEHB) and Postal Services Health Benefit (PSHB).

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.

BlueCard

BlueCard

The BlueCard program is a system that serves Blue Cross and 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 network provider the following applies:

- You are considered a BlueCard PPO (Preferred Provider Organization) provider.
- Eligibility for BlueCard members can be verified through Availity or by calling (800) 676-BLUE [2583].
- Unless otherwise specified on the member ID card submit all claims to the Host 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 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.
- **Electronic Options** — BCBSKS encourages the submission of claims electronically using the ANSI ASC X12N 837 Health Care Claims transactions.
- **Jurisdiction Rules** – Typically, all services provided in the BCBSKS service area (State of Kansas excluding Johnson and Wyandotte counties) should be filed to BCBSKS.

Corrected Claim vs. New 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.

A corrected claim is an update to a previously processed claim with the intent to correct the prior processing. A corrected claim must include all elements from the original submission with changes only applied to the fields being corrected.

When submitting a new claim Box 22 should include the resubmission code 7 along with the original claim control number. For electronic resubmission use loop and segment 2300 CLM05-3 for the claim frequency code 7 and submit the original claim control number in loop and segment 2300 REF02.

Note – to void a claim use resubmission/frequency code 8 along with the original claim control number.

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.

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

Additional instructions for billing immunizations/vaccination codes:

Include the referring/ordering qualifier and NPI listed in box 17 of the 1500 Claim Form.

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.

Split/Shared visit:

When a patient is seen by two providers during the same visit, BCBSKS requires the provider who provides the majority of the service rendered to bill for the service under their own NPI. BCBSKS follows CPT guidelines when choosing and billing for split/shared visits.

Documentation in the medical record must identify the two individual practitioners who performed the split/shared visit. In addition, the individual who performed the substantive portion, and therefore bills the visit, must sign and date the medical record.

Ancillary Billing Guidelines

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:** • 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:** • Field 5 on CMS 1500 Health Insurance Claim Form or • Loop 2010CA on the 837 Professional Electronic Submission **Ordering Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form or • Loop 2420E (line level) on the 837 Professional Electronic Submission **Place of Service:** • 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:** • 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**.	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.
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.		**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 **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**.
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:** • 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, to include Federal Employee Health Benefit (FEHB) and Postal Services Health Benefit (PSHB).

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.

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.
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 member's 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.
- FEP Members – For members insured by FEP plans, FEP medical policy supersedes BCBSKS medical policies.

Preventive Services Quick Reference Guide — This identifies the health care reform preventive health benefits with recommended CPT and diagnosis codes.

BCBSKS-Specific Edits

Diagnosis Coding:

- Code to the highest level of specificity including laterality.

Accident Diagnosis — Use in primary position

Modifiers:

- Modifier 22 – Any unusual professional service, atypical office/outpatient visit fees are eligible for individual consideration when supportive medical records accompany the claim.
- 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 an E/M code with a code that is not subject to the global fee concept.
- Modifier 59 – Payor Specific Edit
    - Recognized only for CPT codes of Lesion Removal (10000's) or Radiology (70000's).
    - Not recognized like Medicare.

Age Recognition —

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

Remittance Advice (RA)

Remittance Advice (RA)

Understanding the Remittance Advice (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.

Claim Control Number

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 along with identifying 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's name.

Claims beginning with 20 indicate they were received in paper form. Claims beginning with 37 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.

Example: 202500500001
20 — The claim came in as a paper claim.
25 — It was received in 2025.
005 — It was received Jan. 5.
00001 — It was the first claim in the sequence.

Specialty Guidelines

Specialty Guidelines

The following Specialty Guidelines can be found on our website.

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

Quality and Disease Management

Disease Management/Wellness

Disease Management/Wellness

The disease management and wellness area provides focused disease management services for chronic conditions such as asthma, coronary artery disease, CHF, COPD, diabetes, hypertension/hyperlipidemia, stress management, weight loss, tobacco cessation and maternity. 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.

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.

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. This list can be found on our BCBSKS website. Providers will submit medical benefit drug reviews for in-scope drugs to Prime's Medical Pharmacy Solutions team by navigating to GatewayPA.com, or via phone at 800-424-1713. Drugs that are typically self-administered by the patient will be requested through CoverMyMeds and/or fax.

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.

More information and a list of specialty medications is available on our website: www.bcbsks.com/prescription-drugs/specialty-pharmacy.

K-TRACS

When prescribing and dispensing opioid medications, BCBSKS encourages all prescribing providers to use Kansas Tracking and Reporting of Controlled Substances(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 Appriss 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 four or five digits, the second segment identifies the drug and will have three or four digits, and the third segment represents the package size and will have one or two 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

Revisions

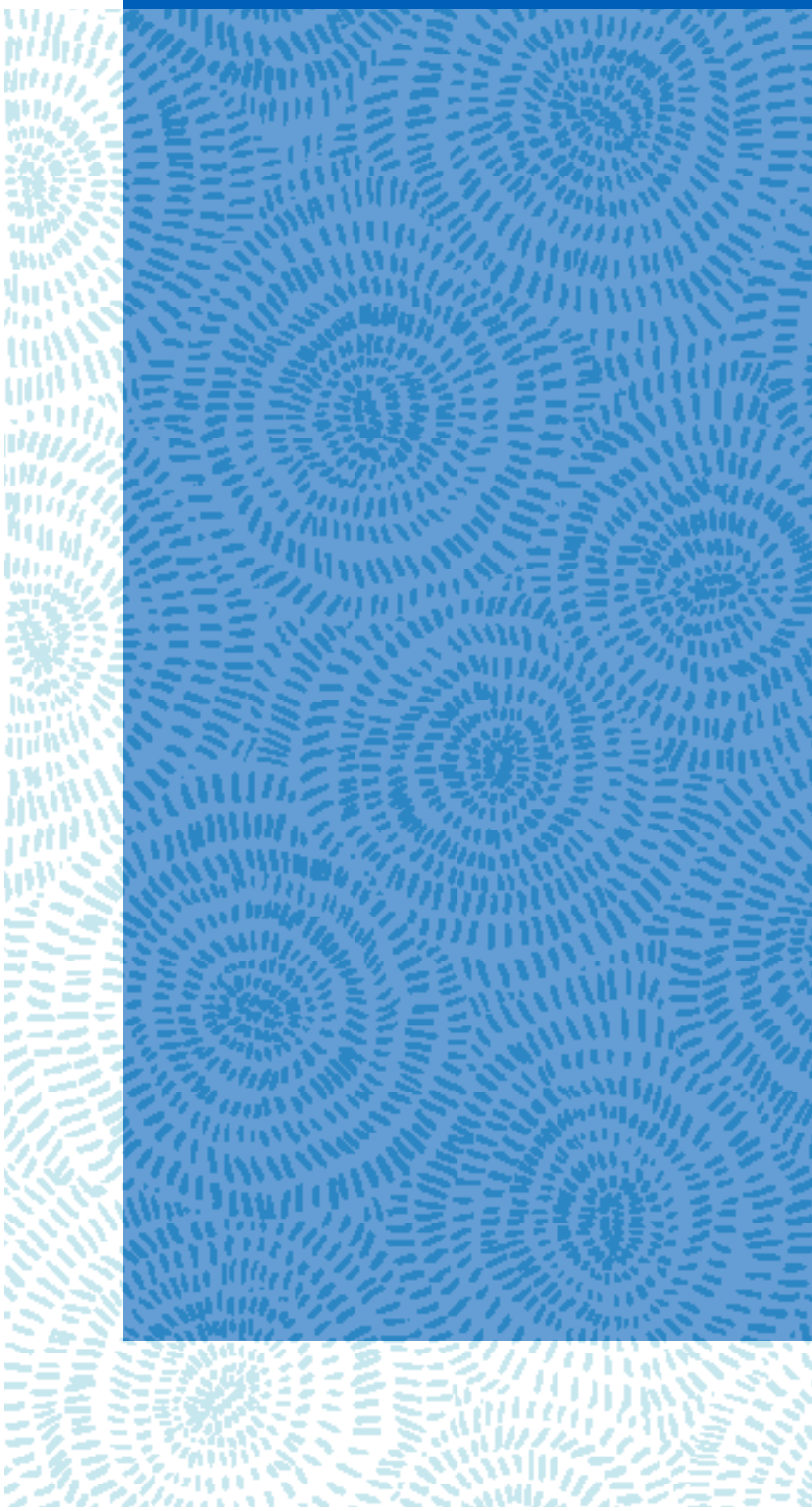
Revisions

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

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
01/01/2024	Page 6 – updated information within policy memo 2: office/outpatient visits section to reflect current information
	Page 11 – updated Provider information to clarify what this section addresses and adding new providers
	Page 13 – Added missing step under Electronic Fund Transfer (EFT)
	Page 15/16 – Updated Network Pricing Group information to reflect current groups
	Page 17 – Updated #3 under Marketplace products section
	Page 19 – Updated MA rep phone number
	Page 27 – Updated Administration and Immunization Reimbursement information to reflect current codes and guides
	Page 27 – Added Split/shared visit section
	Page 28 – Removed Remittance Advice rejection codes section
	Page 32 – Updated information on Reimbursement policies to reflect current information
	Page 33 – Updated Modifier information to reflect current guides and for clarification
	Page 45 – moved section Remittance Advice (RA) to page 37
	Page 48 – Updated Disease Management/Wellness section to reflect current disease management practices

	Page 54 – updated New Directions Behavioral Health to Lucet
	Page 54 – Moved Important Contact information and Professional relations information to page 6
01/01/2025	Updated throughout manual to state FEP includes Federal Employee Health Benefit (FEHB) and new Postal Services Health Benefit (PSHB)
	Page 5 – Updated Important Contact Information section
	Page 13 – Updated Provider Network Enrollment Request timeline to align with credentialing and URAC timeframe
	Page 15 – Added how BCBSKS will follow up
	Page 19 – Updated #3 to Risk Adjustment/Data Validation Audit
	Page 23 – Added image of ID card
	Pag 30 – Switched qualifier codes and split/shared visit sections around
	Page 33 – Updated Preventive Services Quick Reference Guide section
	Page 33 – Updated Limited Patient Waiver section
	Page 34 – Updated BCBSKS-Specific Edits (diagnosis coding bullets)
	Page 38 – Clarified Understand the RA and Updated Paper vs. Electronic to Claim Control number
	Page 40 – Updated Specialty guideline manuals
	Page 50 – Updated Case Management section
01/01/2026	Removed sections Important Contact Information, Member ID Cards and OPL
	Removed information duplicated to additional resources in sections Important Contact Information, CAP, Provider Information, Products/Marketplace, Medicare Advantage, Claims Filing, Reimbursement Policies and Remittance Advice
	Page 5 – Added Termination Based on Professional Competence or Conduct information
	Page 13 – Updated Provider Information section to reflect current names and practices
	Page 27 – Updated BlueCard section to clarify information
	Page 30 – Clarified information regarding corrected Claim vs New claim
	Page 31 - Clarified information regarding split/shared visit
	Page 34 – Added FEP member information under Medical Policies header
	Page 35 – Clarified information under Modifiers
	Page 53 – Updated information under Prior Authorization



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BlueCross BlueShield Kansas

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