BLUE CROSS AND BLUE SHIELD OF KANSAS
PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2023

Following is a summary of the changes to Blue Shield Policies and Procedures for 2023. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com by December 2022.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2022 Policy Memos. Deleted wording is noted by strikethrough. New verbiage is identified in red.

Policy Memo No. 1
SECTION X. Waiver Form

- **Page 11:** Updated verbiage for clarity that the waiver form does not exempt provider write-off.

  NOTE – The waiver cannot be utilized for services considered to be content of another service provided, nor can it be used to bill the patient the difference between the provider charge and the allowed amount.

Policy Memo No. 1
SECTION XXV. Tiered Reimbursement and Provider Number Requirements

- **Page 22:** Updated verbiage to add clarity for tiered reimbursement.

  BCBSKS has established different MAPs for the same service for the following specialties: Advanced Practice Registered Nurses/Advanced Registered Nurse Practitioners, Physician Assistants, Clinical Psychologists, Licensed Clinical Social Workers, Community Mental Health Centers, Outpatient Substance Abuse Facilities, Autism Specialists, Individual Intensive Support providers, Registered Behavior Technician, Chiropractors, Physical Therapists, Certified Physical Therapist Assistants, Licensed Athletic Trainers, Licensed Dieticians, Occupational Therapists, Certified Occupational Therapist Assistants, Speech Language Pathologists, Licensed Clinical Marriage and Family Therapists, Licensed Clinical Professional Counselors, and Licensed Clinical Psychotherapists. Please review your charge comparison (refer to Section XXXVI. CHARGE COMPARISON REPORTS) to determine any write-off amounts.

  Eligible providers listed above must obtain an NPI and assure it is included as the rendering provider number on all claims submitted before any payment for such claims will be made by BCBSKS. Members may not be billed for services when a claim has not been paid because of the lack of the rendering provider NPI. Clinical laboratory, radiology, and drug MAPS are excluded from tiered reimbursement and will apply base MAP.

Policy Memo No. 6
Opening Paragraph

- **Page 3:** Updated verbiage to clarify and not assume concurrent care is hospital care only, clarify that waiver was not ever needed, and that medical records are needed only upon request, not with claim submission.

  Concurrent care takes place when two or more providers render medical and/or surgical services to the same patient on ~~during~~ the same day ~~period of hospital confinement~~. Concurrent professional care may be covered if a Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) consultant concurs that supplementary skills by separate providers were medically necessary on the case. BCBSKS reserves the right to review claims as necessary. Contracting providers will write off charges in cases where review consultants determine that concurrent care was not medically necessary (see Policy Memo No. 1 and No. 5). There is one exception: If the patient has been notified by the physician that BCBSKS may deny the service but continues to insist the service be rendered anyway, the physician can bill the patient for these services if the patient was informed in advance and a signed waiver form is kept on file at the provider's place of business. (The waiver form is not ~~no longer~~ required with claims submission. Use the GA modifier for all electronic and paper claims.) For further information, see Policy Memo No. 1, Section IX.

  The medical necessity for concurrent care services must be substantiated by the medical records, upon request.

Policy Memo No. 6
SECTION I. Instances When Concurrent Care Policy Applies

- **Page 3:** Updated verbiage to add clarity regarding what services apply.

  Two or more providers rendering medical (non-surgical) services to the same patient on the same day.

  Two or more providers rendering any combination of surgical and/or medical services to the same patient on the same day.

  Any case where consultation is followed by daily care by the consulting provider in addition to continuing care by the attending provider.

Policy Memo No. 6
SECTION II. Instances Where Concurrent Care Policy Does Not Apply

- **Page 3:** Added verbiage for clarity regarding when concurrent care does not apply.

  G. Same provider specialties, different diagnosis

  H. Same diagnosis, different provider specialties

Policy Memo No. 9
SECTION I. Global Fee Concept

- **Page 3:** Updated verbiage to clarify major surgery days and consistency using days.

  To determine the global period for major procedures, count one day immediately before the day of the procedure, the day of the procedure and 42 days ~~six weeks~~ immediately following the day of the procedure.

Policy Memo No. 9
SECTION I. Global Fee Concept

- **Page 4:** Updated verbiage to clarify major surgery days and consistency using days.

  A. Components of a Global Surgical Package

  6. Postoperative Visits
  Follow-up visits during the postoperative period of the procedure that are related to recovery are 42 days ~~six weeks~~ for major and ten days for minor procedures. Postoperative visits may be billed for zero day procedures.

Policy Memo No. 9
SECTION I. Global Fee Concept

- **Page 5:** Updated verbiage for consistency.

C. Services not included in the Global Surgical Package

7. Modifier ~~"~~78~~" modifier~~ is used to identify a separate but related procedure being rendered during a postoperative period of another procedure. When appending modifier "78", the original postoperative period ends and a new postoperative period begins, (e.g., major surgery is performed, on day 35 a second related procedure is performed).

8. BCBSKS will deny payment if one of the modifiers (22, 24, 25, 78) is not billed with a service furnished during a global period. These modifiers were established to facilitate physician billing and processing of services that are not included in the global package.

9. When a service performed is considered a lesser service and billed with a modifier ~~"~~52~~" modifier~~, reimbursement may be reduced to an allowance reflective of the service performed.

Policy Memo No. 9
SECTION VII. Unusual Circumstances

- **Page 4:** Updated verbiage for consistency in the use of modifier.

Surgeries for which the services performed are significantly greater than usually required may be billed with the modifier 22 ~~modifier~~ added to the CPT code for the procedure.

Policy Memo No. 11
SECTION II. Endoscopies, Arthroscopies, and Other Scope Procedures

- **Page 3:** Updated verbiage for consistency in the use of modifier.

  For two or more surgical scope procedures that involve multiple compartments or sections of the same anatomic area (including but not limited to joints, sinuses, and abdominal, chest, pelvic, and cranial cavities), only the procedure with the highest RVU will be reimbursed; other procedures shall be considered content of service. Exceptions based on unusual clinical intensity and/or use of physician resources are also available on a claim-by-claim basis; such claims will only be considered for additional reimbursement if ~~M~~modifier 22 and appropriate supporting records are submitted with the original claim.

Policy Memo No. 12
SECTION V. Method of Determining the Maximum Allowable Payment (MAP)

- **Page 4:** Added verbiage to ensure clarity of processing of anesthesia units.

  A. PROFESSIONAL ALLOWANCES
  Professional allowances for general anesthesia are determined as follows:
  1. Anesthesia base points of the CPT/American Society of Anesthesiologists (ASA) codes, plus
  2. One point per each 15 minutes of administration.
  3. Anesthesia units are rounded up to the next whole number for payment purposes.
  NOTE – The above are multiplied by the BCBSKS anesthesia conversion factor.

Policy Memo No. 12
SECTION VI. Related Policies

- **Page 4:** Updated verbiage for consistency in the use of modifier.

  A. UNUSUAL CASES
  When the condition of the patient relative to the surgical procedure to be performed is such as to imply an unusual risk, consideration of an unusual fee may be provided. In such cases, it is necessary to use ~~M~~modifier 22 and send medical information that will substantiate the case and document direct attendance. It is acknowledged that unusual detention with the patient is eligible for additional time charges. Contracting providers agree to accept the review process determination in such cases.