2024 Behavioral Health Workshop

BlueCross BlueShield Kansas

What can your Rep do for you

- Insurance billing education
- CAP mailing
- Policy Memos
- Documentation
- Coding
- On-site Visits

Important Contact Information

BlueCross BlueShield Kansas

Customer Service Center (CSC)

Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.

Questions regarding:
- Claim status
- Appeals
- Pre-determinations
- Benefits
- Eligibility

Contacts:
Email: csc@bcbsks.com
Phone: 800-432-3990 or 785-291-4180
Fax (written inquiries and predets): 785-290-0711
Fax (all others): 785-290-0783

CSC Providers Only Benefits Line

Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.

Questions regarding:
- Benefits
- Eligibility

Contacts:
Email: csc@bcbsks.com
Phone: 800-432-0272 or 785-291-4183

Provider Network Services

Hotline Hours: Monday-Wednesday, and Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Contracting
- Credentialing
- Network enrollment

Contacts:
Email: prof.relations@bcbsks.com
Phone: 800-432-3587 or 785-291-4135
Fax: 785-290-0734

Availity® Essentials

Office Hours: Monday - Friday 7:00 a.m. - 6:00 p.m.

Contact Availity Client Services toll free at 800-Availity (800-282-4548) or log in to Availity Essentials to submit a support ticket.

Availity Client Services is available during the hours listed above.

BlueCard®

Eligibility for out-of-state members:
- Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.
- Phone: 800-676-BLUE (800-676-2583)

Claim info for out-of-state members:
- Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.
- Phone: 800-432-3990, ext. 4058

Case Management

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Assistance with coordination of care for patients with complicated health issues.

Contacts:
Phone: 800-432-0216, ext. 6628 or 785-291-6628
For FEP members: 800-782-4437, ext. 6611

MiResource

Contacts: Email: support@miresource.com

Lucet

Office Hours: 24/7/365

Questions for behavioral health care:
- Preauthorizations
- Outreach services for high-risk patients
- Coordination with behavioral health care

Contacts:
Phone: 800-952-5906
Fax: 816-237-2364

Medicare Advantage

Office Hours: Monday - Friday 8:00 a.m. - 6:00 p.m.

KS members or M3A prefix
- Provider Services: 800-240-0577 Fax: 800-976-2794
- Prior Authorization/Utilization Management/Care Transition: 800-325-6201 Fax: 877-218-9089
- After Hours Utilization Management/Care Transition: 800-331-0192 Fax: 877-218-9089
- Behavioral Health Services (Lucet): 877-589-1635
- Hearing Services: 800-334-1807
- Vision Services: 877-226-1115

Federal Employee Program (FEP) - All FEP inquiries except OPL

Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.

Contacts:
Phone: 800-432-0379 or 785-291-4181
Fax: 785-290-0764

FEP Blue Dental Contacts:
Phone: 855-504-2583
www.bcbsfepdental.com

Electronic Data Interchange (ASK-EDI) - Payor ID: 47163

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Electronic claims transmission
- Electronic RA
- Billing software
- Clearinghouse services
- Internet file transfer and passwords
- Real-time vendors

Contacts:
Email: askedi@ask-edi.com
Website: ask-edi.com
Phone: 800-472-6481 or 785-291-4178
Fax: 785-290-0720

Fraud Hotline

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Reporting of any illegal activity involving BCBSKS. Callers may remain anonymous.

Contacts:
Phone: 800-432-0216, ext. 6400 or 785-291-7000, ext 6400.

Other Party Liability (OPL) & Pre-Existing

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Duplicate coverage
- No-fault auto exclusion
- Subrogation
- Workers' compensation
- Pre-existing

Contacts:
Phone: 800-430-1274 or 785-291-4013
Fax: 785-290-0771

Pre-certification, Concurrent Review and Alternate Care

Office Hours: Monday - Friday 8:00 a.m. - 5:00 p.m.

Questions regarding:
- All hospital inpatient admissions

Contacts:
Phone: 800-782-4437

Teleorder

Office Hours: 24/7/365

Contacts:
Phone: 800-346-2227 or 785-291-8130

Location Address:
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Billing Address:
P.O. Box 239
Topeka, KS 66601-0239

Provider Information

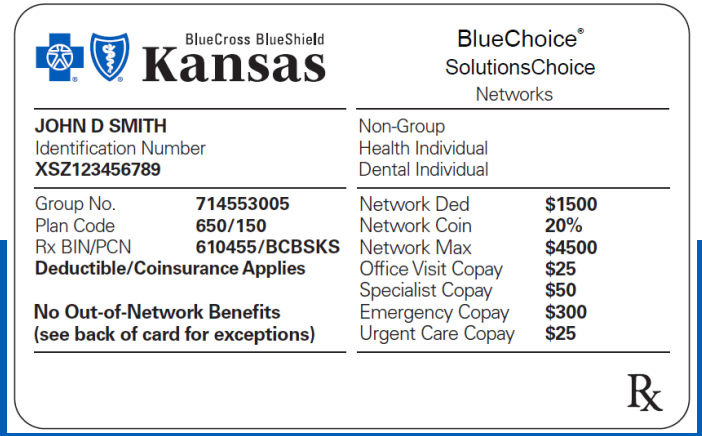
- Provider Change Request Form
  https://www.bcbsks.com/documents/provider-information-change-form-15-141-2022-04-19
- Provider Network Enrollment Request Form
  https://www.bcbsks.com/documents/provider-network-enrollment-request-15-481-2021-11-23
- Initiate request at least 60 days before start date
- BCBSKS does NOT backdate the contract effective date because of URAC requirements
- CAQH must be current
- BCBSKS Credentialing Program
  https://www.bcbsks.com/providers/professional/publications/credentialing-information

BCBSKS ID Cards

- Majority have a three-digit prefix (i.e.. XSB, KSE)
- Suitcase (PPO, PPOB, Empty, MA PPO, No Logo)
- No Suitcase (EPO) – No BlueCard benefits – can't travel
- Co-pays and deductibles listed
- Medical and Dental (if applicable)
- Group number
- CSC phone number on the back

BlueCare EPO

- Non-emergent, out-of-area care requires a prior authorization
- Covered benefits are for the BCBSKS service area
  - Request to receive service outside of Solutions Network form
- Zero coverage if the member is referred to a non-contracting entity for any service, including lab and radiology.
- Special contract with The University of KS Health System (KU Med in KC) and Children's Mercy



Prefixes for EPO members

- XSN – Individual on Exchange
- XSZ – Individual off Exchange
- KSA – Small Group off SHOP

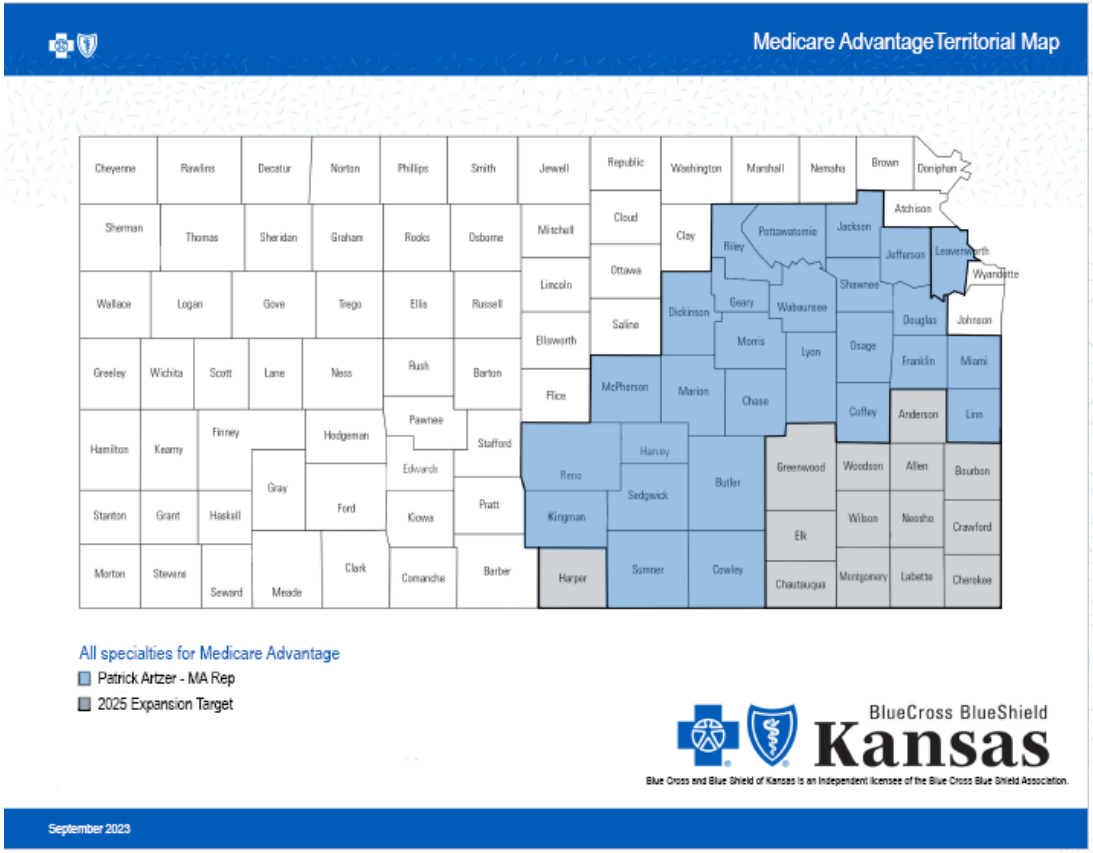
BlueCard

- BlueCard program serves BCBS members worldwide.
- "BlueCard" is the term used for out-of-state plans.
- One source (Host Plan) for providers for claims submission.
- Claim Filing – All medical claims for out-of-state Blue Plans file to BCBSKS
- Terminology
  - HOME Plan: The BCBS plan where the patient's policy was issued.
  - HOST Plan: The BCBS plan where the services are rendered.

Medicare Advantage

- 27 Counties, including Sedgwick and Shawnee
- Medicare rates and policies apply
- No additional premiums for added services
- Not included in the QBRP
- Prefix – M3AK
- MA Provider Representative – Patrick Artzer
  - Patrick.Artzer@bcbsks.com
  - 785-291-6289

Medicare Advantage



Limited Patient Waiver

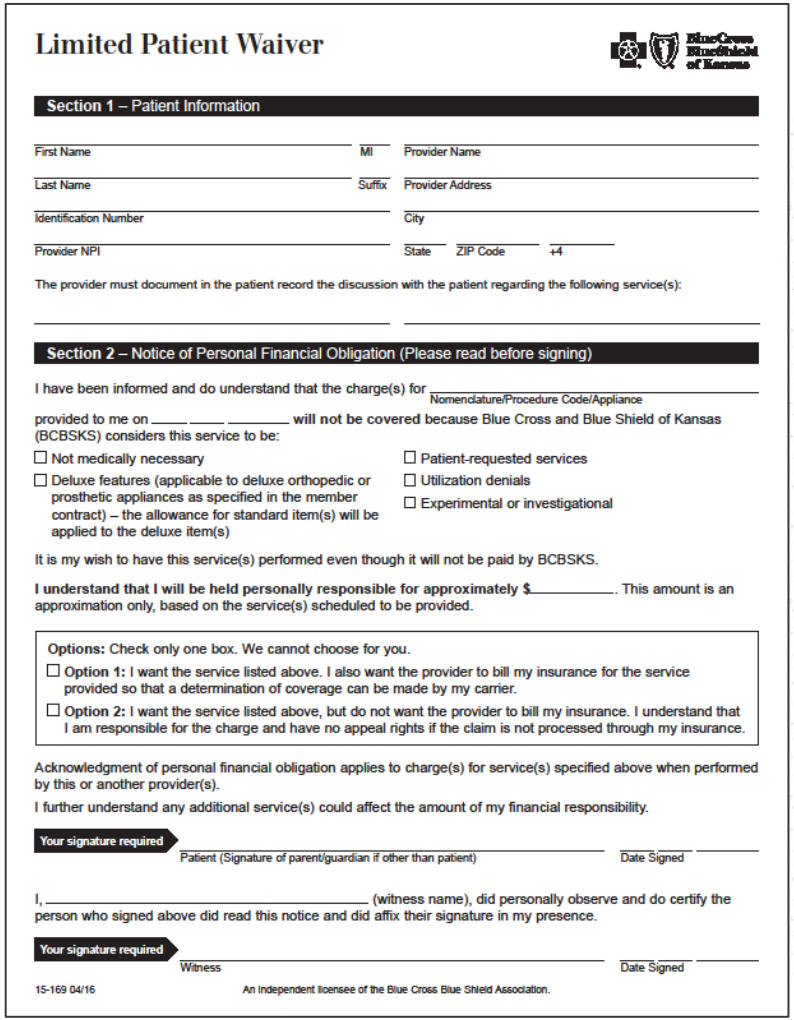
THE WAIVER FORM MUST BE:

1. Signed before receipt of service.
2. Patient, service, and reason specific.
3. Date of service and dollar amount specific
4. Retained in the patient's file at the provider's place of business.
5. Patient request on an individual basis. It may not be a blanket statement signed by all patients.
6. Acknowledged by patient that he or she could be personally responsible for the charge amount listed on the Waiver.

Note: If the waiver is not signed before the service being rendered, the service is considered a contractual provider write-off, unless there are extenuating circumstances.

Note: Service should be billed with a –GA

Limited Patient Waiver



Limited Patient Waiver

Blue Cross Blue Shield of Kansas

Section 1 – Patient Information

First Name | MI | Provider Name

Last Name | Suffix | Provider Address

Identification Number | City

Provider NPI | State | ZIP Code | +4

The provider must document in the patient record the discussion with the patient regarding the following service(s):

Section 2 – Notice of Personal Financial Obligation (Please read before signing)

I have been informed and do understand that the charge(s) for _____
Nomenclature/Procedure Code/Appliance

provided to me on ____ ____ _____ **will not be covered** because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service to be:

- ☐ Not medically necessary
- ☐ Deluxe features (applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) – the allowance for standard item(s) will be applied to the deluxe item(s)
- ☐ Patient-requested services
- ☐ Utilization denials
- ☐ Experimental or investigational

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS.

I understand that I will be held personally responsible for approximately $_____. This amount is an approximation only, based on the service(s) scheduled to be provided.

Options: Check only one box. We cannot choose for you.

- ☐ **Option 1:** I want the service listed above. I also want the provider to bill my insurance for the service provided so that a determination of coverage can be made by my carrier.
- ☐ **Option 2:** I want the service listed above, but do not want the provider to bill my insurance. I understand that I am responsible for the charge and have no appeal rights if the claim is not processed through my insurance.

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

Your signature required _____ Date Signed _____
Patient (Signature of parent/guardian if other than patient)

I, _____ (witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

Your signature required _____ Date Signed _____
Witness

15-169 04/16 An Independent licensee of the Blue Cross Blue Shield Association.

Documentation

- M.E.A.T.
- Must be legible, signed, and dated (EHR must include a time stamp)
- Abbreviations
- Patient Identifiers (name, DOB, account#) – Minimum of 2 on each page
- Requirements for timed codes
- See Section III of BCBSKS Behavioral Health Manual
- professional-provider-behavioral-health-manual-2024 (bcbsks.com)

Uniform Charging

What constitutes a provider's usual charge?

- A discount to every patient without health insurance would be considered the "usual charge," and you must bill BCBSKS the same amount.
- Only collect deductible, co-payment, co-insurance, or non-covered services at the time of service

Concierge/Club Services are not to be offered to BCBSKS members

Uniform Charging

Sliding Scale NOT allowed except for the following (due to agency regulations):

- Community mental health centers
- County health departments

Cash Pay Discount (including non-insured):

- Based upon individual patients' situations (for example: patient hardship or professional courtesy)
- Must be documented in the patient record
- If offered a discount for cash, provider must bill BCBSKS the same amount
- If a provider gives a lower charge to every patient who does not have health insurance, we consider that lower charge to be the "usual charge"
- Professional provider services where the provider would normally make no charge, a claim should not be submitted

Claims Filing

Timely Filing

- BCBSKS: 15 Months from DOS
- FEP: by Dec. 31 of the year after the year the service was received
- Self Funded Groups and Blue Card may have different timeframes

CMS 1500 (06/05)

- beta.bcbsks.com/cms1500/

EDI

- ASK-EDI home page | ASK-EDI
- 800-472-6481

Claims Filing

- Eligible contracting providers must file services under their own billing NPI
- BCBSKS does not recognize “Incident To” billing

NOTE: Services provided by a student CANNOT be billed under the supervising therapist’s NPI

Diagnosis Coding

- The ICD-10-CM codes are used for claims submissions including behavioral health and substance use claims.
- The DSM-5 is used for clinical and research application with its provision of diagnostic criteria.
- Use current Diagnoses and Procedure codes
- SDoH Z-codes: Should be used as a supplemental diagnosis code, when appropriate

Place of Service (POS)

Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.

The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the health care industry.

Location	POS
Office	11
Telehealth Other	02
Telehealth Home	10
Home (non-telehealth)	12
School	03

Modifiers

- A medical coding modifier is two characters (letters or numbers) appended to a CPT or HCPCS Level II code.
- Providers additional information about the medical procedure, service, or supply involved without changing the meaning of the code.
- Can be information or pricing.
  - A pricing modifier is a medical coding modifier that causes a pricing change for the code reported
  - Informational modifiers should be placed after all pricing modifiers.
- Common modifiers for Behavioral Health:
  - GA – Waiver on file
  - GT – Telehealth service
  - Q6 – Locum Tenens

Telemedicine

- Patient requested not provider driven
- Telemedicine is service with audio, visual or audio/visual – Does not include emails, faxes, or texts
- Provider MUST be licensed in the state the patient is located at time of service
- POS 02 (other) or 10 (home)
- GT Modifier
- If provider lives outside of Kansas, provider must be credentialed with and must bill to that state's Blue Plan
- 2024 All services pay at parity

Professional Services Coordinated with a Non-Contracting Provider

Must use other contracting providers for all professional services

- Includes professional component, technical component or other technology utilized in the performance of a service
- Includes genetic testing and labs

Referrals/orders to non-contracting providers

- Contracting/ordering provider must bill BCBSKS for all services rendered by the non-contracting provider
- Contracting/ordering provider will be required to ensure the member is held harmless if billed by the noncontracting provider

Providers pending credentialing/contracting

- Should not see BCBSKS members until credentialing is complete
- The group must hold the member harmless for these services

If requested by the member/patient

- Have member/patient sign a waiver or statement acknowledging full understanding of the non-contracting referral and the patient's financial responsibilities.
- Should be filed in the patient's chart

Retrospective Review

- 120 days from date of Remittance Advice
  - Written inquiry

    https://secure.bcbsks.com/bcbsks-provider/facelets/allUsers/form/ProviderClaimEnrollmentInquiry.faces

- Void Claim
  - CMS 1500: Box 22 use #8 claim frequency code indicator and ICN # of the respective claim to be voided
  - Wait for verification of voided claim on remittance advice before submitting a new claim

- Corrected Claim
  - CMS 1500: Box 22 use #7 claim frequency code indicator and ICN# of the respective claim being corrected
  - Do not write “Corrected Claim” on the claim form
  - The submission of the corrected claim should report all services provided on that visit, even if paid on the original claim.

Appeals

- “Not Medically Necessary” denials only
- 1st Level: Written notification within 60 days from Retrospective Review Determination
- 2nd Level: Written request within 60 days from 1st Level Appeal

Audits

- Post Pay Audits
- Fraud and Abuse
- Utilization
- Appeals
  - 1st Level: Written notification within 30 days of notification of the findings
  - 2nd Level: Written request within 30 days from 1st Level Appeal determination

Remittance Advice

- Located in Blue Access via Availity
- QBRP Prerequisite
- Includes details on finalized claim
- Claim Adjustment Reason Codes (CARC)
- Remittance Advice Remark Codes (RARC)
- https://x12.org/codes

Claim Control Number Examples

252412300001

- 25 – Electronic claim
  - * 20 – Paper Claim
  - * 57 – Blue Card Claim
- 24 – It was received in 2024.
- 123 – It was received on May 3rd (Julian date).
- 00001 – It was the first claim in the sequence.

Availity

Contact Availity for:

- Registration (www.Availity.com)
- Password issues
- Changes/updates to Availity provider profile
  - TIN / NPI changes
  - Name / address changes
- Questions regarding other Payers
- 1-800-Availity

Availity/Blue Access - BCBSKS

On Availity site:

- Eligibility and Benefits
- Claim Status

On Blue Access:

- Patient ID Search: for BCBSKS members
- Provider Information
- Provider Information Forms: Attestation, Business Associate Agreements (BAA), Electronic Message Portal
- Remittance Advice: View / Print Remits
- QBRP: QBRP Earned Report
- Resources (i.e. EFT enrollment)

MiResource

- Online mental health provider directory
- Filtered by patient's specific needs/preference
- In-person or Telemedicine
- To request invitation to sign up:

  support@miresource.com

Competitive Allowance Program (CAP)

- Annual Contract Update
- Emailed towards the end of July
- Reimbursement Changes for upcoming year
- Quality Based Reimbursement Program (QBRP)
- https://www.bcbsks.com/documents/2024-cap-annual-report

Quality Based Reimbursement Program

- Details are in the CAP report
- Allows the Provider the opportunity for increased revenue
- Prerequisites
- BH incentives
- Qualifying periods
- SDoH
- Reach out to your Provider Rep to schedule an appointment to review in detail

Specialty Guidelines

Heather Schultz, Specialty Provider Representative

- Heather.Schultz@bcbsks.com

Specialty Guidelines found on the BCBSKS.com website

- Autism Guidelines
- professional-provider-autism-manual-2024 (bcbsks.com)

Thank you for being a BCBSKS contracting provider