

Physical Medicine Workshop

June 9, 2026



Workshop Overview

Agenda

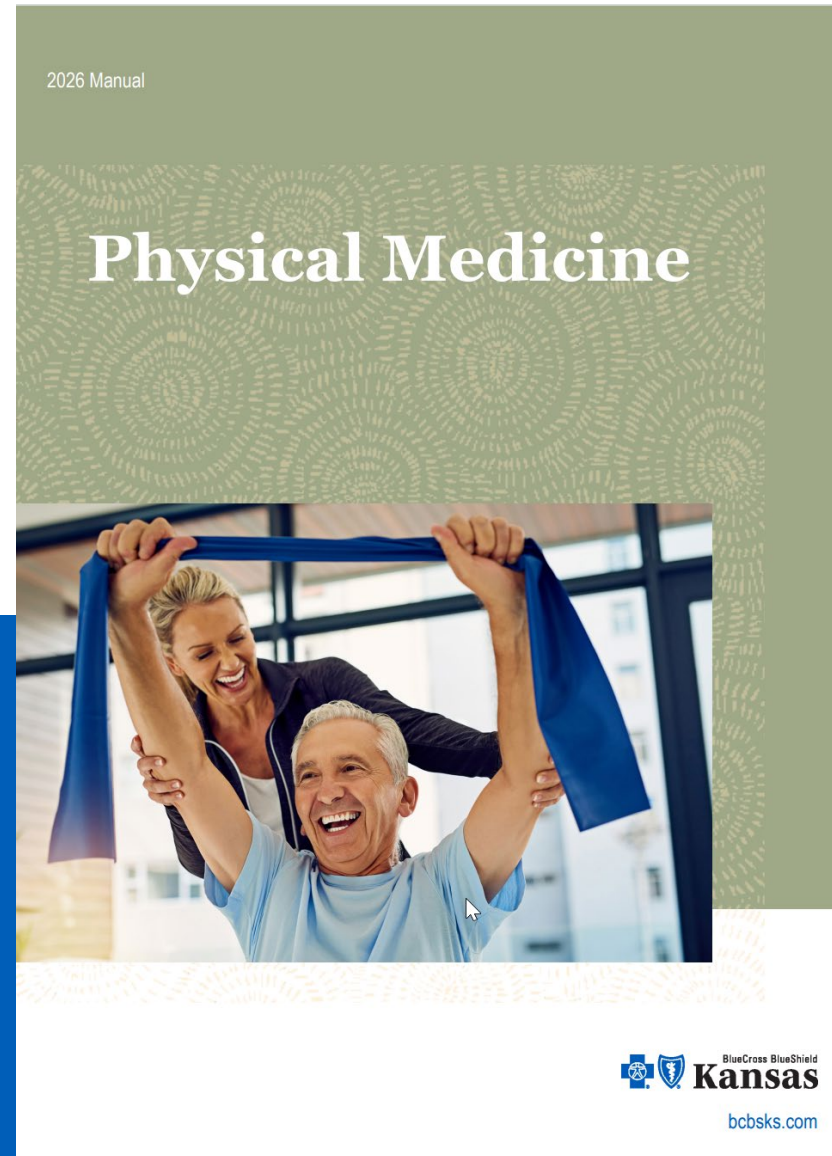
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Physical Medicine Manual

Using the Manual

- Quick reference for BCBSKS coding and policy
- Searchable using Ctrl-F





Active vs. Maintenance Care

Defining Active Care

What is Active Care?

Active Care is treatment aimed at improving the patient's condition, as long as improvement is possible. Active care is actively working toward a better medical outcome.

Documentation and Compliance

Documenting correct diagnosis and rationale for ongoing active care in a treatment plan supports medical necessity and payer compliance.

Patient Communication

Effective communication helps patients understand Active Care goals and expected treatment outcomes. When discussing care, be clear about the outcome you are seeking.

Transition to Maintenance Care

Care transitions from active to maintenance are based on clinical outcomes and patient progress evaluation. Once the patient "plateaus" or cannot achieve any better medical outcome, the care becomes maintenance.

Defining Maintenance Care

Treatment Stabilization

Maintenance Care involves treatment after reaching maximum improvement or condition stabilization to prevent regression.

Symptom Management vs Functional Improvement

Patients may still have pain, but care focuses on symptom management rather than further functional gains.

Patient Communication and Policies

Explaining care differences to patients and using Limited Patient Waiver and GA modifier when continued care is requested without improvement.

BCBSKS Policies and Documentation

It is essential to understand BCBSKS policies and provide thorough documentation.

Maintenance Care is not covered by BCBSKS.



Limited Patient Waiver



Limited Patient Waiver (LPW)

Purpose

LPW is essential for Maintenance Care and Experimental services, ensuring patient understanding and compliance.

Completion Requirements


LPW must be completed before each encounter with clear explanation of the need for the waiver.

Use of GA Modifier

The GA modifier is used to indicate services requiring LPW, according to the manual's guidelines.

Best Practices

Proper documentation and clear communication improve compliance and patient understanding of LPW.

Limited Patient Waiver 

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 Patient-requested services
 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) 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.



Policy Memos



Policy Memos

1. Policies and Procedures
2. Office/Outpatient
3. Outpatient Treatment of Accidental Injuries
4. Quality of Care
5. In-Hospital Medical
6. Concurrent Professional Care
7. Radiology and Pathology
8. Obstetrical Services
9. Surgery
10. Assistant Surgery
11. Multiple Surgical Procedures
12. Anesthesia



Policy Memo No. 1

Policies and Procedures

Retrospective Review/Corrected Claims

- 120 days from date of remittance advice for a retrospective review.
- Corrected claims must be submitted within timely filing limits.
- 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
- Risk Assessment



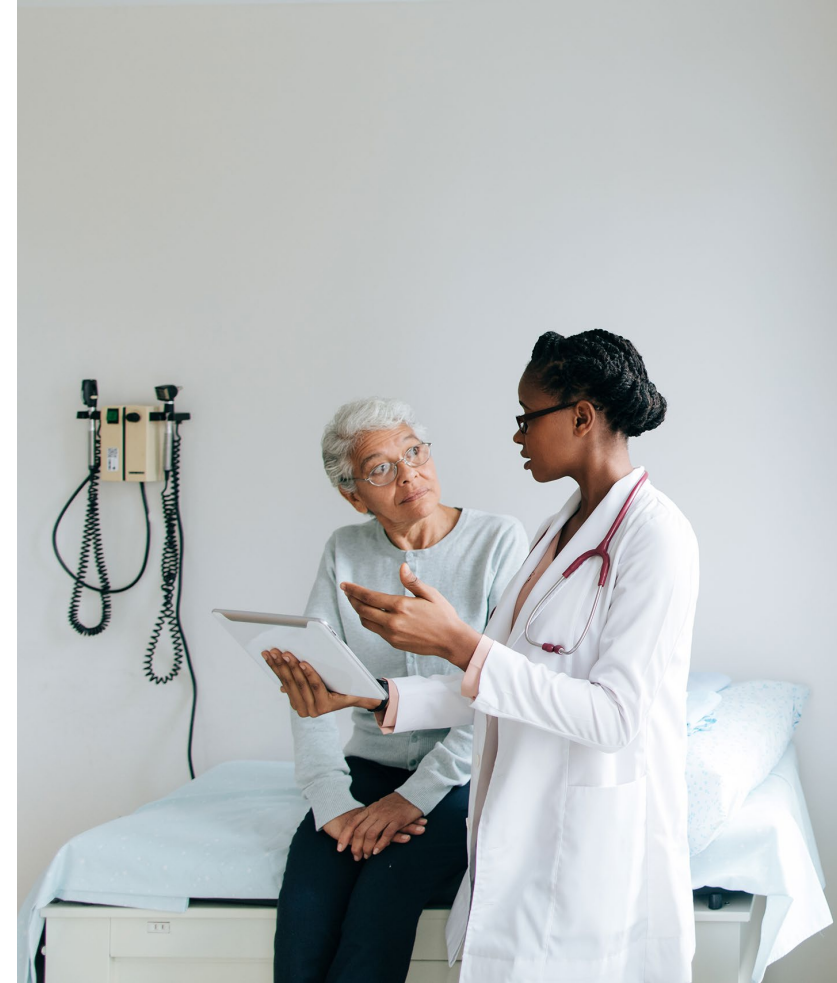


Content of Service

- Therapeutic, prophylactic or diagnostic injection administration provided on the same day as an office, home or nursing home visit
- Telephone calls and web-based correspondence
- Additional charges beyond the regular charge. Ex – after office hours, holidays or emergency
- See Policy Memos 1 and 2 – not all-inclusive list

Services Coordinated with a Non-Contracting Provider

- Contracting/ordering provider must bill BCBSKS for all services rendered by the non-contracting provider.
- If a member requests a referral to a non-contracting provider, a signed statement of financial obligation should be on file.
- Contracting/ordering provider will be required to ensure the member is held harmless if billed by the non-contracting provider.





Refund & Right of Offset Policy

- BCBSKS uses auto-deduction processes for Right of Offset for claims previously paid.
- BCBSKS must request refunds within 15 months from the date of adjudication.
- Refund requests for fraudulent claim payments and duplicate claim payments – including other party liability claims – are not subject to the 15-month limitation.



Claims Filing

- BCBSKS does not recognize “incident to”
 - Eligible contracting providers must file services under their own individual NPI
- Contracting provider agrees to file claims for all covered services.
- Timely filing
 - BCBSKS - 15 months from date of service
 - FEP - by Dec. 31 of the year after the year the service was received OR 15 months from the date of service, whichever comes first
 - ASOs - may have different timely filing requirements
- Use current diagnosis and procedure codes

Non-Covered Services

- Professional services are not reimbursed when provided to an immediate family member – spouse, children, parents, siblings or legal guardian of the person who received the service (or themselves).
- Member's contract may determine categories of services, procedures, equipment and/or pharmaceuticals. These denials are billable to the member.





Documentation and Requirements

Standards for Documentation

Clinical Documentation Methods

SOAP and MEAT notes ensure clarity and compliance. Always include the chief complaint, initial diagnosis, and codes.

Documentation Checklists

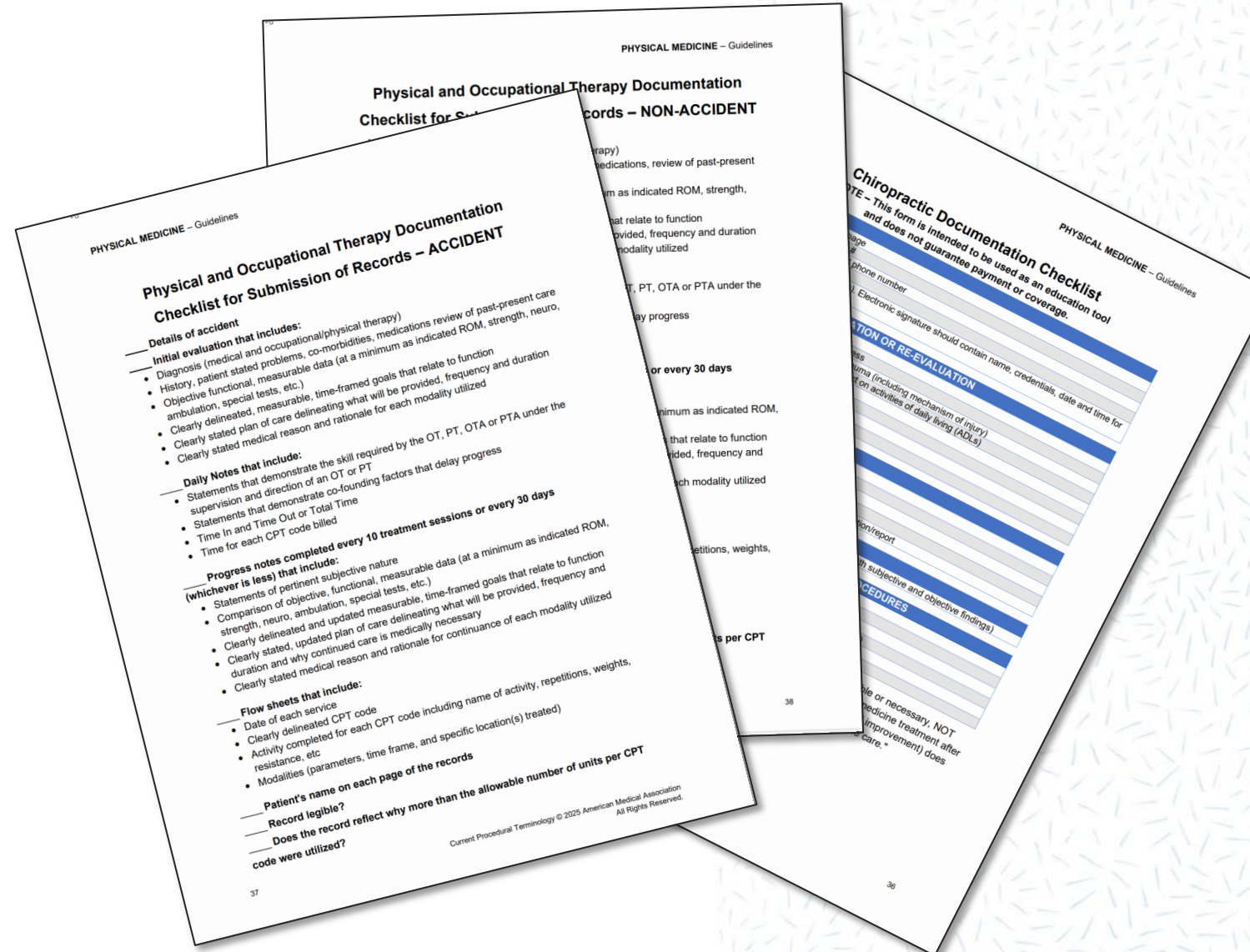
Chiropractic, PT and OT documentation help distinguish between accident and non-accident. Avoid “cloned” records. Abbreviations need a legend.

Accurate Medical Records

Submit electronic records via ANSI 271 and Provider Message Portal.

Avoiding Documentation Pitfalls

Strategies and templates ensure completeness, accuracy and reduce common documentation errors.





Telemedicine Policy

Telemedicine Services Not Allowed in Physical Medicine

Policy Memo No. 2, VI. Telemedicine states:

Physical therapy, occupational therapy and audiology services are not covered telehealth services.





Imaging and Low-Back Pain QBRP

LBP QBRP Incentive Guidelines

Imaging Protocols for LBP

Imaging within the first 28 days for low back pain to ensure appropriate use and reduce unnecessary imaging – x-ray, MRI and CT scan.

QBRP Incentive Targets

Given when 90% of members or more did not have imaging within the 28 days of diagnosis. Groups must have 5 attributed/eligible members, and solo providers must have one.

Compliance and Reimbursement

Stay updated on guidelines to maximize compliance with QBRP and optimize reimbursement.





Coding and Billing



Helpful Reminders and Resources

Workshop Format and Resources

Professional Billing 360 workshop offers in-person CEU sessions and online resources to support billing education.

Importance of Accurate Coding

Essential for reimbursement and compliance, minimizing errors and ensuring proper claims processing.

BlueMA Taxonomy Requirements

Helps classify services and providers correctly to meet regulatory standards.

The screenshot shows the Kansas BlueCross website. The top navigation bar includes links for Providers, Brokers, News, About Us, Contact Us, and a Search icon. A BlueAccess Login button is in the top right. Below the navigation is the Kansas logo and a menu with options: Institutional, Professional, Medical Policies, Prior Authorization, Medicare Advantage, and COVID-19. The breadcrumb trail reads: HOME / PROVIDERS HOME / PROFESSIONAL PROVIDER HOME / PROFESSIONAL PROVIDER EDUCATION AND WORKSHOPS. The main heading is "Professional Provider Education and Workshops". Below this is a "WORKSHOPS" section with the text "In-depth training opportunities at locations around the state." and a list of links: "2026 BCBSKS Provider Webinar: Driving Quality, HEDIS® & Risk Adjustment Performance", "Blues Tour Workshops", "Professional Billing 360- Navigating the Provider Pathway", "Behavioral Health Workshops", "BCBS Annual Workshop", "Dental Workshops", and "What's New Annual Workshops". At the bottom of the screenshot is a "WEB-BASED EDUCATION" section.



Provider Resources



Resources at Your Fingertips

Essential Provider Manuals

Includes Physical Medicine Manual, Professional Provider Manual and HEDIS Coding and Reference Guide for clinical and coding guidance.

Forms and Reports

Covers the 2026 fee schedule, OPL form, Provider Information form, QBRP Tracker and CAP Report for compliance and reporting.

Communication and Support

Utilize Provider Message Portal, newsletters, policy memos and contact Provider Relations Representative for assistance and updates.

Accessing Digital Resources

BlueAccess via Availity provides an online platform to access resources, stay informed, and complete administrative tasks efficiently.



Provider Relations