6 – FACILITY AND ANCILLARY PROVIDERS

Overview

A facility provider is an alcohol or drug treatment center, day surgery center, home health care, hospice, home infusion agency, skilled nursing facility, hospital, or other facility that is licensed or certified to perform designated, covered health care services by the state or jurisdiction where services are provided.

An ancillary provider is a supplier of health care related equipment or services such as durable medical equipment (DME), prosthetics, orthotics, drugs, medical supplies, etc.
Table of Contents

Overview .................................................................................................................................... 1
Table of Contents....................................................................................................................... 2
6.1 Facility and Ancillary Responsibilities ................................................................................... 3
  6.1.1 Network Hospitals .......................................................................................................... 3
  6.1.2 Responsibilities .............................................................................................................. 3
  6.1.3 Interpreter Services ....................................................................................................... 4
6.2 Facility and Ancillary Reimbursement ................................................................................... 4
  6.2.1 Diagnosis Related Groups ............................................................................................. 4
  6.2.2 Fixed-Fee Arrangements ............................................................................................... 4
  6.2.3 Maximum Per Diem ....................................................................................................... 6
  6.2.4 Emergency Services ..................................................................................................... 6
6.3 Member Share – Copay, Coinsurance, and Deductibles ...................................................... 6
  6.3.1 Collecting Member Share .............................................................................................. 6
  6.3.2 Emergency and Urgent Care Member Share ................................................................. 6
  6.3.3 Inpatient Hospital Member Share ................................................................................... 7
  6.3.4 Outpatient Member Share .............................................................................................. 7
6.4 Medical Policy and Member Benefits .................................................................................... 7
  6.4.1 Medical Policy ................................................................................................................ 7
  6.4.2 Experimental, Investigational, or Unproven Services ..................................................... 8
6.5 Preventable Adverse Events ................................................................................................. 9
  6.5.1 Overview ....................................................................................................................... 9
  6.5.2 Serious Reportable Events ............................................................................................. 9
  6.5.3 Hospital Acquired Conditions ....................................................................................... 11
  6.5.4 Present on Admission Indicator .................................................................................... 12
  6.5.5 Reimbursement Policy .................................................................................................. 13
6.1 Facility and Ancillary Responsibilities

6.1.1 Network Hospitals
BCBSNM members must select a hospital within the network of contracted BCBSNM facilities unless they have preauthorization from the Medical Director or his/her designee, or unless their plan allows their use of non-contracted services (usually at his/her out-of-pocket expense). BCBSNM members using network hospitals will receive a higher benefit level than they would if services were rendered in an out-of-network hospital.

6.1.2 Responsibilities
For BCBSNM members, facility providers must:

- Participate in preadmission review processing for preauthorization.
- Participate in claims review for determination of medical necessity.
- Participate in length-of-stay monitoring and control.
- Assist in proper preauthorization processing for hospital services.
- Participate in utilization review, including responding to requests for information from BCBSNM personnel.
- Participate in peer review.
- Participate in quality improvement activities and efforts to systematically improve patient safety.
- Participate in facility credentialing activities.
- Comply with the BCBSNM member complaint and grievance procedure.
- Submit other insurance information to BCBSNM.
- Notify BCBSNM immediately of change in accreditation or licensing status or of federal sanctions.
- Use BCBSNM-contracted ancillary providers, hospitals, pharmacies, laboratories, radiologists*, and behavioral health professionals and physicians.
- Comply with BCBSNM Quality Management and Improvement (QMI) and Utilization Management (UM) requirements.
- Collect only deductible, coinsurance (based on contract allowable), and specified copayments from BCBSNM members for office visits, and charges for non-covered services.
- Submit professional claims on CMS-1500 forms and facility claims on the UB-04 form (see Section 8, Claims Submission).
- Obtain a referral from the PCP for any service that requires preauthorization before services are rendered (see Section 10, Preauthorization).
- Submit encounter and claims information accurately and timely (see Section 8, Claims Submission).
- Maintain confidentiality of all member records.
- Maintain medical records for members following regulatory guidelines (see Medical Record Documentation Standards at bcbsnm.com/provider).
- Follow all state regulations, such as Health Department reporting requirements.
- Notify BCBSNM of changes to provider information as defined in Section 4, Professional Provider Responsibilities.
6. Facility and Ancillary Providers

• Comply with BlueCard® requirements as set forth in the BlueCard Program Provider Manual, included in this Provider Reference Manual.

• If participating as a Blue Cross Community CentennialSM provider, comply with the requirements set forth in the Blue Cross Community Centennial Section.

• Comply with appropriate professional standards and licensure requirements.

6.1.3 Interpreter Services

Contracted providers are expected to provide an interpreter for limited English proficient individuals and interpretative services for patients who qualify under the Americans with Disabilities Act (ADA). Providers need to arrange for the service using an interpreter service of their choice. Once the service is provided, the provider may submit an invoice for reimbursement to:

Provider Servicing
PO Box 23151
Waco, TX 76702

If you have any questions, please call 817-826-8343.

6.2 Facility and Ancillary Reimbursement

6.2.1 Diagnosis Related Groups

The most common method of reimbursing inpatient care at hospitals is through Diagnosis Related Groups (DRGs). DRGs are a system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and presence of complications. DRGs are considered a fixed-fee arrangement for services rendered under a defined length of stay. Reimbursement under the DRG methodology can be altered based upon lower- or higher-than-usual lengths of stay.

Present on Admission (Section 6.5.3, below) indicator must be completed for each diagnosis code submitted on the claim.

6.2.2 Fixed-Fee Arrangements

Fixed-fee arrangements reflect a negotiated rate for services rendered in which the provider assumes a degree of financial risk or gain. Different fixed-fee arrangements include: inpatient hospital per diems, inpatient hospital case rates, outpatient case rates, and outpatient maximum allowable fee schedules. The Resource Based Relative Value Scale (RBRVS) based fee schedule and DRG hospital rates are fixed-fee arrangements.
Note: For further information on RBRVS, see Section 5, Professional Provider Reimbursement.
6.2.3 Maximum Per Diem

Most home health care, hospice, or home infusion agencies, as well as skilled nursing facilities, are reimbursed billed charges up to the per diems as defined by the services rendered. Per diems are inclusive of all services and supplies based on the type of provider. Inclusive services are defined in the facility provider’s Medical Services Entity Agreement.

6.2.4 Emergency Services

Acute general hospitals are reimbursed for emergency services provided in compliance of federal mandates, such as the “anti-dumping” law in the Omnibus Reconciliation act of 1989, P.L. (101-239) and 42 U.S.C. Section 1395dd. (1867 of the Social Security Act).

6.3 Member Share – Copay, Coinsurance, and Deductibles

6.3.1 Collecting Member Share

Facility and ancillary providers are required to collect member share at the time the service is provided. Check the member’s ID card for the proper member share amount to collect. If you are unaware of the status of the deductible, collect 10 percent of the service being provided. You may have to refund the member after the Provider Claims Summary (PCS) arrives and you can determine the exact member share. Member share is inclusive of State gross receipts tax.

6.3.2 Emergency and Urgent Care Member Share

The emergency care member share is collected by the emergency room at an acute care hospital.

The urgent care member share is collected when a member is seen at an urgent care center. Check the member share amount on the member’s ID card.

See Section 10, Preauthorization for additional information on emergency and urgent care services.
6.3.3 Inpatient Hospital Member Share

The inpatient hospital member share is collected by the hospital for an inpatient admission.

The inpatient surgery member share is collected by the hospital where inpatient surgery is performed. When pre- and post-operative visits are included in a global surgical fee, no office visit member shares are collected for those visits.

In maternity cases, the delivery member share is collected by the hospital.

6.3.4 Outpatient Member Share

When outpatient ambulatory surgery is performed in an ambulatory surgery unit, the copayment is equal to the outpatient copayment.

See Section 7, Member Information for restrictions, responsibilities, and exclusions.

6.4 Medical Policy and Member Benefits

6.4.1 Medical Policy

Medical policies are based on data from peer-reviewed scientific literature, from criteria developed by specialty societies, and from guidelines adopted by other health care organizations. Medical policies are used to make benefit coverage determinations. In the event of conflict between a medical policy and any Plan document, the Plan document will govern.

Facility and ancillary providers are required to review BCBSNM medical policy information as these policies may impact your reimbursement and your patients’ benefits. Approved new or revised medical policies and their effective dates are posted on our website the first day of each month. To view all Active or Pending policies, visit bcbsnm.com/provider under Standards & Requirements. In addition, you may click on the Draft Medical Policies link to view policies that are under development or are being revised and submit your comments via email.

All providers are encouraged to contribute their constructive comments to the draft medical polices for consideration by the HCSC Medical Policy Group.
6.4.2 Experimental, Investigational, or Unproven Services

Facility and ancillary providers are responsible for being familiar with services that may not be covered by BCBSNM, such as procedures that may be considered experimental and/or investigational. If a procedure or diagnostic service is considered experimental and/or investigational, you must inform the member that they may incur financial responsibility. (See below for further information on experimental, investigational, or unproven services.)

Experimental, investigational, or unproven services include any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice, as defined below. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is considered experimental and will not be covered.

**Standard medical practice** means the use of services or supplies that are in general use in the medical community in the United States, and which meet the following criteria:

- The services or supplies have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated.
- The services or supplies are appropriate for the hospital or other facility provider in which they were performed.
- The physician or other professional provider administering the services or supplies has had the appropriate training and experience to provide the treatment or procedure.

For a treatment, procedure, facility, piece of equipment, drug, device, or supply to be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, or efficacy as compared with the standard means of treatment or diagnosis.
- The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.
- The service must be medically necessary and not excluded by any other contract exclusion.
Note: Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol(s) used by the treating facility, or the protocol(s) of another facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. Experimental, investigational, or unproven does not mean cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

Note: Under FEP, a drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA); and, approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA. BCBSNM has a Medical Review department that determines whether a claimed service is experimental or investigational after consulting with internal or external experts or nationally recognized guidelines in a particular field or specialty.

6.5 Preventable Adverse Events

6.5.1 Overview

BCBSNM defines Preventable Adverse Events (PAEs) are defined as “adverse events that are serious, largely preventable, and of concern to both the public and health care providers for public accountability.” They include both Hospital-Acquired Conditions (HAC) as identified by the Centers for Medicare & Medicaid Services (CMS), as well as Serious Reportable Events (SREs) as defined by the National Quality Forum (NQF).

BCBSNM will apply the following five principles or guidelines when a serious hospital acquired condition or Never Event occurs:

- The error or event must be preventable.
- The error or event must be within control of the hospital.
- The error or event must be a result of a mistake by the hospital.
- The error or event must result in significant harm.
- Identification of non-payable events will incorporate case-by-case review and determination by a Medical Director, except when self-reported and without dispute.

6.5.2 Serious Reportable Events

SREs, as defined by the NQF, are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers. This list of SREs has since evolved to account for a range of clinical settings where patients receive care, including office-based practices, ambulatory surgery centers, and skilled nursing facilities.
Providers are required to report on a claim if a SRE occurs.

The SREs are:

1. **Surgical or invasive procedure events**
   a. Surgery or other invasive procedure performed on the wrong site
   b. Surgery or other invasive procedure performed on the wrong patient
   c. Wrong surgical or other invasive procedure performed on a patient
   d. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
   e. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient

2. **Product or device events**
   a. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
   b. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
   c. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

3. **Patient protection events**
   a. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
   b. Patient death or serious injury associated with patient elopement (disappearance)
   c. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

4. **Care management events**
   a. Patient death or serious injury associated with a medication error
   b. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
   c. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
   d. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
   e. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
   f. Artificial insemination with the wrong donor sperm or wrong egg
   g. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
   h. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. **Environmental events**
   a. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
   b. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
   c. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
d. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

6. Radiologic events
   a. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

7. Potential criminal events
   a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
   b. Abduction of a patient/resident of any age
   c. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
   d. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

6.5.3 Hospital Acquired Conditions

Hospital Acquired Conditions (HACs) are those conditions that are acquired by a patient while they are in the inpatient hospital setting and were not present upon admission to the hospital.

HACs selected by CMS must meet the following criteria:

- Conditions must be high cost, high volume or both.
- Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis.
- Could reasonably have been prevented through the application of evidence-based guidelines.

The 14 categories of HACs include:

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage III and IV pressure ulcers
5. Falls and Trauma
   a. Fractures
   b. Dislocations
   c. Intracranial injuries
   d. Crushing injuries
   e. Burns
   f. Other injuries
6. Manifestations of poor glycemic control
   a. Diabetic ketoacidosis
   b. Nonketotic hyperosmolar coma
   c. Hypoglycemic coma
   d. Secondary diabetes with ketoacidosis
   e. Secondary diabetes with hyperosmolarity
7. Catheter-associated urinary tract infection (UTI)
8. Vascular catheter-associated infection
9. Surgical site infection, mediastinitis, following Coronary Artery Bypass Graft (CABG)
10. Surgical site infection following bariatric surgery for obesity
   a. Laparoscopic gastric bypass
   b. Gastroenterostomy
   c. Laparoscopic gastric restrictive surgery
11. Surgical site infection following certain orthopedic procedures
   a. Spine
   b. Neck
   c. Shoulder
   d. Elbow
12. Surgical site infection following Cardiac Implantable Electronic Device (CIED)
13. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following certain orthopedic procedures:
   a. Total knee replacement
   b. Hip replacement
14. Iatrogenic pneumothorax with venous catheterization

6.5.4 Present on Admission Indicator

To facilitate the identification of HACs not present on admission, new coding requirements were effective October 1, 2008. For every diagnosis code reported, one of the following Present on Admission (POA) indicators must also be reported:

- Y - Present on admission
- W - Based on data and clinical judgment, it is not possible to document when the onset of the condition occurred
- N - Not present on admission
- U - Documentation is insufficient to determine if the condition was present at the time of admission.
- 1 - Exemption from POA reporting*

Regardless of your contract reimbursement, BCBSNM does require that you file the POAs on all inpatient hospital claims.

At this time, the following hospitals are exempted by CMS from filing the POA Indicator:

- Long-Term Acute Care Hospitals (LTCHs or LTACs),
- Inpatient Rehabilitation Facilities (IRFs),
- Inpatient Psychiatric Facilities (IPFs),
- Cancer Hospitals
- Children's Hospitals

Note: Does not apply to Blue Cross Community Centennial claims. Medicaid’s HCAC includes Medicare’s IPPS hospitals, as well as other inpatient hospital settings that may be IPPS exempt under Medicare.

* For a complete list of codes on the POA exempt list, see the ICD-10-CM Present on Admission Exempt List at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html
6.5.5 Reimbursement Policy

BCBSNM reserves the right in its sole discretion not to pay for any costs related to, or arising out of, a PAE. Without limitation and by way of examples only, any professional provider whose act or omission caused or materially contributed to the PAE may not be reimbursed nor may services in the operating or procedure room where the PAE occurs be reimbursable by BCBSNM.

Contracted providers will hold harmless members for any services related to, or arising out of, the PAE. A Provider whose act or omission caused or materially contributed to the PAE shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Member for identified PAEs.