6 – Facility and Ancillary Providers

Overview

Introduction

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.

Contents

This section contains the following topics:

<table>
<thead>
<tr>
<th>Section</th>
<th>See Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Facility and Ancillary Responsibilities</td>
<td>6-2</td>
</tr>
<tr>
<td>6.1.2 Interpreter Services</td>
<td>6-3</td>
</tr>
<tr>
<td>6.2 Facility and Ancillary Reimbursement</td>
<td>6-4</td>
</tr>
<tr>
<td>6.2.1 Diagnosis Related Groups</td>
<td>6-4</td>
</tr>
<tr>
<td>6.2.2 Fixed-Fee Arrangements</td>
<td>6-4</td>
</tr>
<tr>
<td>6.2.3 Maximum Per Diem</td>
<td>6-4</td>
</tr>
<tr>
<td>6.2.4 Emergency Services</td>
<td>6-4</td>
</tr>
<tr>
<td>6.3 Member Share – Copay, Coinsurance, and Deductibles</td>
<td>6-5</td>
</tr>
<tr>
<td>6.3.1 Collecting Member Share</td>
<td>6-5</td>
</tr>
<tr>
<td>6.3.2 Emergency and Urgent Care Member Share</td>
<td>6-5</td>
</tr>
<tr>
<td>6.3.3 Inpatient Hospital Member Share</td>
<td>6-5</td>
</tr>
<tr>
<td>6.3.4 Outpatient Member Share</td>
<td>6-5</td>
</tr>
<tr>
<td>6.4 Medical Policy and Member Benefits</td>
<td>6-6</td>
</tr>
<tr>
<td>6.4.1 Medical Policy</td>
<td>6-6</td>
</tr>
<tr>
<td>6.4.2 Experimental, Investigational, or Unproven Services</td>
<td>6-6</td>
</tr>
<tr>
<td>6.5 Never Events and Hospital Acquired Conditions</td>
<td>6-9</td>
</tr>
<tr>
<td>6.5.1 Never Events</td>
<td>6-9</td>
</tr>
<tr>
<td>6.5.2 Hospital Acquired Conditions</td>
<td>6-10</td>
</tr>
<tr>
<td>6.5.3 Present on Admission Indicator</td>
<td>6-11</td>
</tr>
</tbody>
</table>
6.1 Facility and Ancillary Responsibilities

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.

Responsibilities

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).

Continued on next page
6.1 Facility and Ancillary Responsibilities, Continued

- 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 the end of Section 16, Credentialing).
- 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.
- 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.

6.1.2 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, 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 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 healthcare 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 policies 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.

Continued on next page
6.4 Medical Policy and Member Benefits, Continued

6.4.2 Experimental, Investigational, or Unproven Services

(continued)

**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.

*Continued on next page*
6.4 Medical Policy and Member Benefits, Continued

6.4.2 Experimental, Investigational, or Unproven Services (continued)

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 Never Events and Hospital Acquired Conditions

Overview

It is BCBSNM’s intent not to pay the additional costs resulting from preventable hospital-based medical errors. 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.

These principles will be applied to the Hospital Acquired Conditions (HACs) identified by the Centers for Medicare & Medicaid Services (CMS) as well as to nine National Quality Forum (NQF) Never Events to determine whether reimbursement to the hospital should be reduced for the additional costs related to the event.

6.5.1 Never Events

As defined by the National Quality Forum (NQF), Never Events are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers for purposes of public accounting. Never Events earned that name because these events should never happen in medical practice. Note: All Blue Cross Community Centennial providers are required to report on a claim if a Never Event occurs.

The nine NQF events are:

1. Surgery performed on the wrong body part.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient.
4. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility.
5. An infant discharged to the wrong person.
6. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
7. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life.
8. Artificial insemination with the wrong donor sperm or donor egg.
9. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility.

Continued on next page
6.5 Never Events and Hospital Acquired Conditions, Continued

6.5.2 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.
- Conditions must be represented clearly by an ICD-9-CM diagnosis code.
- Conditions are designated as a Complicating Condition (CC) or Major Complicating Condition (MCC) and would result in the assignment of the case to a higher severity MS-DRG when reported as a secondary diagnosis.
- Conditions must be reasonably preventable through evidence-based guidelines.

The 10 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
   - Fractures
   - Dislocations
   - Intracranial injuries
   - Crushing injuries
   - Burns
   - Electric shock
6. Manifestations of poor glycemic control
   - Diabetic ketoacidosis
   - Nonketotic hyperosmolar coma
   - Hypoglycemic coma
   - Secondary diabetes with ketoacidosis
   - Secondary diabetes with hyperosmolarity
7. Catheter-associated urinary tract infection (UTI)
8. Vascular catheter-associated infection

Continued on next page
6.5 Never Events and Hospital Acquired Conditions, Continued

6.5.2 Hospital Acquired Conditions (continued)

9. Surgical site infection following:
   - Coronary Artery Bypass Graft (CABG) - Mediastinitis
   - Bariatric surgery
     - Laparoscopic gastric bypass
     - Gastroenterostomy
     - Laparoscopic gastric restrictive surgery
   - Orthopedic procedures
     - Spine
     - Neck
     - Shoulder
     - Elbow

10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)
    - Total knee replacement
    - Hip replacement

6.5.3 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.

Continued on next page
6.5 Never Events and Hospital Acquired Conditions, Continued

6.5.3 Present on Admission Indicator (continued)

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-9-CM or ICD-10-CM Present on Admission Exempt List at: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html)*