

All Blue 2009 Workshop

Facility
Breakout Session

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Facility Breakout Session

Pre-admission Services

- 72 HR Outpatient Claims not paid separately, this includes without limitation:
  - pre-admission testing
  - emergency room services that result in the admission
  - observation room services that result in the admission
- Provision includes only services performed at the same (or related) facility as the admission
- System generated message notifies our claim processor to question the admission and discharge date

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CMS-DRG[1] vs. MS-DRG[2]

- Facilities are updated to reimburse the new MS-DRG[2] rates when new contracts agreements become effective.
- DRG assignments made via The Center for Medicare/Medicaid Services (CMS)[1] Based Grouper (version 24) for providers who do not have new agreements

[1] CMS-DRG - Center for Medicare/Medicaid Services Diagnostic Related Group (version 24).

[2] MS-DRG - Medicare Severity Diagnostic Related Group. CMS published MS-DRG (version 25) in October 2007.

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Zero Grouper Encounters

- Group 0 procedures' reimbursement determined by provider's contract
- Agreed upon maximum allowed between the Facility and BlueCross BlueShield of Tennessee is $0.00
- Medically based exceptions may warrant a procedure designated as an office procedure be performed in an outpatient surgical facility.
- Submit reconsiderations for payment of Group 0 on provider dispute form with the operative report attached

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Scenario: Zero Grouper Encounters

Issue

You submit a claim for a surgical procedure, but there is no payment assigned to the surgery.

Resolution

- The code may be assigned to grouper zero, which is classified as minor surgical services and payment is specific to contract agreement.
- You may submit a reconsideration including the operative report if you feel there was a medical need for the facility setting.

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Code Bundling Rules

- Evaluate the accuracy and adherence of medical claims to accepted national standards
- Applied during the claim payment process
- Some edits can only be applied when all associated claims are processed
- Can occur on multiple levels depending on the combination of codes reported
- Supplemental information may be requested

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Scenario: Code Bundling Rules

Issue

You receive a remittance advice showing a claim has been recouped with explanation code W72.

Resolution

- Review the code bundling section of the provider page on the company Web sites, bcbst.com and vshptn.com.
- Locate the date span and code range that fits the date of service on the claim.
- Search for the comprehensive code and view the codes that are considered components.
- If you disagree, you may submit a dispute to the address on the original refund request letter.

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Requesting Additional Information

- A service that is rarely provided, unusual, variable, or new, may require a special report in determining medical appropriateness of the service.
- Pertinent information should include an adequate definition or description necessary to provide service.
- Unlisted, miscellaneous and non-specific code for procedures and services should be described

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Requesting Additional Information (cont.)

- **Types of Supplemental Information**
  - A description of the procedure or service provided
  - Documentation of the time and effort necessary to perform procedure or service;
  - An operative report for surgical procedures
- **Reasons for requesting additional information**
  - Unlisted procedures
  - Outlier days
  - Pre-existing information
  - Medical appropriateness

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Specialty Pharmacy

- **Specialty Drugs are classified into two categories:**
  - Self-Administered
  - Provider-Administered

- **Available from one of three Preferred Specialty Pharmacy Vendors:**
  - Caremark Specialty
  - CuraScript, Inc.
  - Accredo Health Group

Select Specialty Pharmacy Rx drugs require Prior Authorization.

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Specialty Pharmacy

- **Self-Administered Specialty Pharmacy Rx** (oral, SQ, select IM's) are obtained by the member:
  - Claims filed by the pharmacy thru Pharmacy Benefits Manager (PBM).
  - Member may have 2 x copay if Specialty Pharmacy Rx vendor is not utilized.
  - Specialty Pharmacy drug claims filed by a practitioner, outpatient facility, or HIT provider, and NOT the PBM, will be denied.
- **Provider-Administered Specialty Pharmacy Rx** (IM, IV)
  - Administered in a practitioner's office, outpatient facility, or by HIT provider and billed as a medical claim. Member may have drug copay.
  - For most plans, Provider-Administered drugs will NOT process thru the PBM as a pharmacy claim.
  - Specialty Pharmacy drugs may be obtained from one of the Specialty Pharmacy Rx vendors and shipped to office with direct billing to BlueCross BlueShield of Tennessee.

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Present On Admission Indicator (POA)

- Claim will reject with an invalid POA
- Electronic claims must have a “1” for the exempt codes. Paper claims must NOT use the “1”.
- Taxonomy code determines facilities exemption from POAs
- Newborn Well Baby claims must have the POA on the claim.
- POA can be found in the Billing Section of *BCBST and VSHP Provider Administration Manuals*

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Corrected Bills

- Corrected bill includes additional/changed dates of service, codes, units, and/or charges.
- Must be received by BlueCross BlueShield of Tennessee within two years of the end of the year the claim was originally received by BlueCross BlueShield of Tennessee.

  Example: If a claim was filed on 2/15/07, any corrected bill must be received by BlueCross BlueShield of Tennessee by 12/31/09.
- Claims may deny duplicate if not resubmitted with the correct bill type.

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Scenario: Corrected Bills

Issue

You have a claim reported on your remittance advice that you notice was filed with the incorrect number of units.

Resolution

- Submit a new claim form with the correct data.
- Attach correspondence behind the claim form indicating what information was originally submitted and what has changed on the new claim form.
- Make sure the last digit of the bill type is 6, 7, or 8 on your CMS-1450 claim form.

OR

- In the 2300 Loop, the CLM segment (claim information), the CLM05-3 (claim frequency type code) must indicate the third digit of the type of bill being sent is 6, 7 or 8.
- In addition, in the 2300 Loop, the REF02 segment (Original Reference Number (ICN/DCN)) must include the original claim number issued to the claim found on your electronic claims receipt confirmation report and remittance advice.

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All Other Services

- Defined as those services that cannot be appropriately categorized.
- Services will be considered under the All Other Outpatient Services section of the contract unless performed with an all-inclusive service.
- Standard all-inclusive services include:
  - Emergency room visits
  - Surgical groupers
  - Observation charges

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Non-covered Services*

- Members can be billed for non-covered services due to benefit limitations such as, dollar limits or service limits.
- Network providers may bill the member* the difference between the limit amount and the allowed amount.

Example: Dollar Limit

Member has a $250 limit on wellness services with no co-payment. The Member has already used $100 on wellness services.

Billed amount	$450
Allowed amount	$325
Remaining benefit	$150
Member liability	$175
Provider write-off	$125

* Applies to Commercial only

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Non-covered Services*

Example: Service Limit

The Member's coverage allows for one Pap smear per calendar year. The Member has already used this benefit for the year.

Billed amount	$65
Allowed amount	$30
Member liability	$30 (allowed amount)
Provider write-off	$35 (difference of allowed versus billed)

* Applies to Commercial only

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Non-covered Services*

- Revenue codes considered Member liability and may be billed to a BlueCross BlueShield of Tennessee Member follow:

Revenue Code	Service
0624	FDA Investigational Devices
0990	General - Patient Convenience Items
0991	Cafeteria/Guest tray
0992	Private Linen Service
0993	Telephone/Telegraph
0994	TV/Radio
0995	Non patient Room Rentals
0996	Late Discharge Charge
0997	Admission Kits
0998	Beauty Shop/Barber
0999	Other Patient Convenience Items

* Applies to Commercial only

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Non-contracted Services

- Non-contracted denials: non-contracted procedures billed or services billed under the incorrect provider entity
- Non-contracted services include:
  - Emergency room revenue code billed with procedure other than those specific codes listed in the Schedule 2 contract.
  - Services that require specific contract agreement
  - Rehab services billed under the acute care provider number
  - Outpatient services billed without the required procedure code

* Applies to Commercial Only

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Behavioral Health* vs. Medical

- Acute care provider number with a behavioral health diagnosis code will deny remittance explanation code X10.
- Medical records may be needed to determine what component of the contract to which the charges should apply.
- Reconsiderations for payment should be submitted on the provider dispute form to the Provider Service Organization for review.

* Applies to Commercial members only

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Scenario: Behavioral Health* vs. Medical

Issue

You receive a claim denial for an inpatient stay with explanation code X10.

Reason for Denial

The DRG is excluded from the acute care contract.

Resolution

- Verify that the claim is billed for true medical services and not behavioral health services.
- Submit a dispute form or an electronic dispute via the Web site and request that the claim be reviewed for medical benefits.
- Medical records may also be needed for the review to be completed.

* Applies to Commercial members only

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W26 Explanation Code

- The W26 explanation code incorporates several reasons for claim denials (see Billing Guidelines):
  - Unlisted procedure codes
  - Invalid code combinations
  - Outpatient services filed without the appropriate corresponding procedure code

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Scenario: W26 Explanation Code

Issue

You receive a W26 denial on your remittance for an emergency room visit.

Resolution

- Review the claim to validate that the revenue code for the emergency room visit was submitted with a valid procedure code.
- If there is no procedure code, submit a corrected bill including the appropriate contracted emergency room visit code.

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National Provider Indicator (NPI)

- The National Provider Identifier (NPI) became a required data element effective January 1, 2008.
- Form locator 5 requires the facility tax ID number.
- Form locator 56 requires the facility NPI number.
- Form locator 81CC should be populated with the taxonomy code assigned for the service provided.

5 FED TAX NO

56 NPI	

81CC			
1			
2			

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Scenario: National Provider Identifier (NPI)

Issue

You receive a rejection on a claim stating the provider cannot submit BlueCross BlueShield of Tennessee claims.

Resolution

- Review the claim to validate the NPI and tax ID are correct
- Ensure the correct taxonomy is used in form locator 81CC if you have more than one type of facility charges being billed under the same tax ID and NPI.
    i.e. Rehabilitation charges should be billed with the taxonomy for rehab facility and not the acute care taxonomy.

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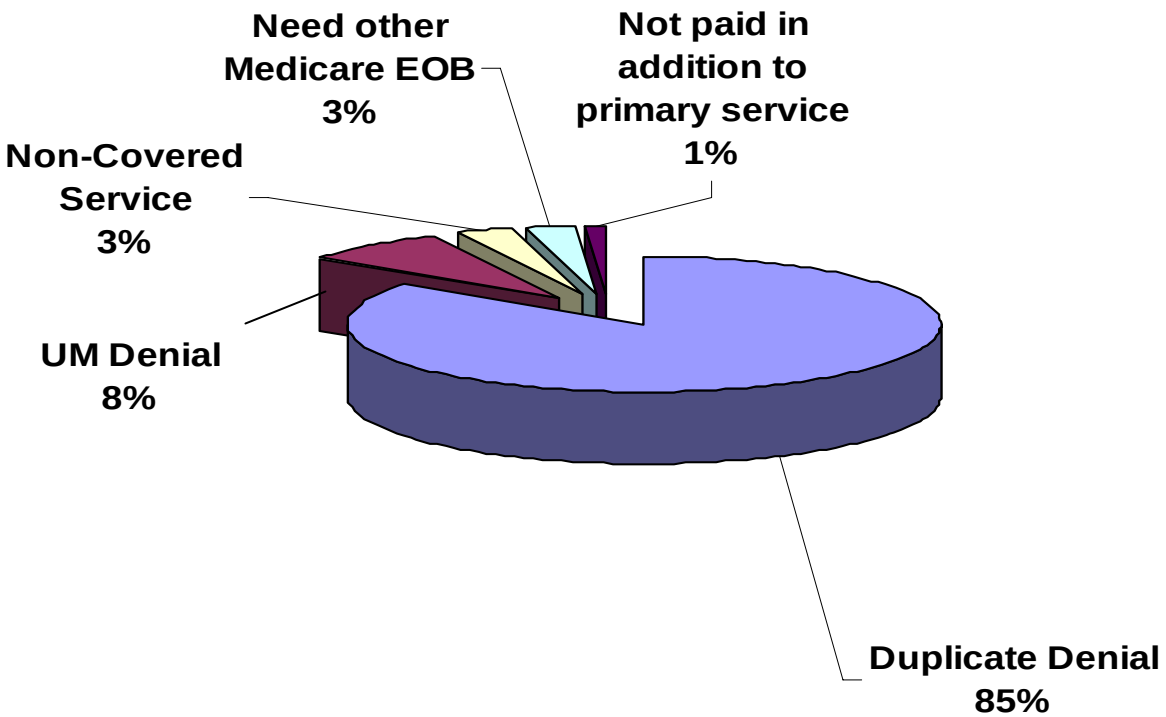
Top Denial Reasons*



* Sample of Commercial claims only

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Scenario: Duplicate Denial

Issue

You receive a duplicate denial with either explanation code SHD or DUP.

Reason for denial

The claim submitted matches a previously submitted claim that has been reported on a remittance advice.

Resolution

- If the claim is a correction to the original, then you should follow the corrected bill guidelines by including 6, 7, or 8 as the last digit in the type of bill on the CMS-1450 claim form.
- If you are submitting additional correspondence for a previously processed claim, do not attach a copy of the claim. Send the information on the Provider Dispute Form located on our Web site.
- Verify claim status through the BlueAccess or by calling the provider service line at 1-800-924-7141. Do not submit copies of claims to request status.

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Scenarios: BlueCare/TennCare*Select* Claim Denial

Issue

You receive a claim denial code of WB9…….The provider must submit a valid National Drug Code (NDC), units and quantity qualifier before benefits can be provided.

Reason for denial

Claim was filed without the NDC information.

Resolution

Resubmit the claim with the correct NDC information and mark as a corrected claim.

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Scenarios: BlueCare/TennCare*Select* Claim Denial

Issue

You receive a claim denial code of WB7…….A completed consent form is required from the provider before this service can be considered for benefits.

Reason for denial

VSHP does not have the consent form or information is missing from the consent form.

Resolution

Refer to the ASH consent forms tip sheets. Complete the consent form and reference the denied claim number.

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Questions?

1. Ask now

2. Visit with the Panel of Experts

3. Call Provider Service

- Commercial 1-800-924-7141
- BlueCare 1-800-468-9736
- TennCare*Select* 1-800-276-1978