

All Blue 2010

Facility

Breakout Session

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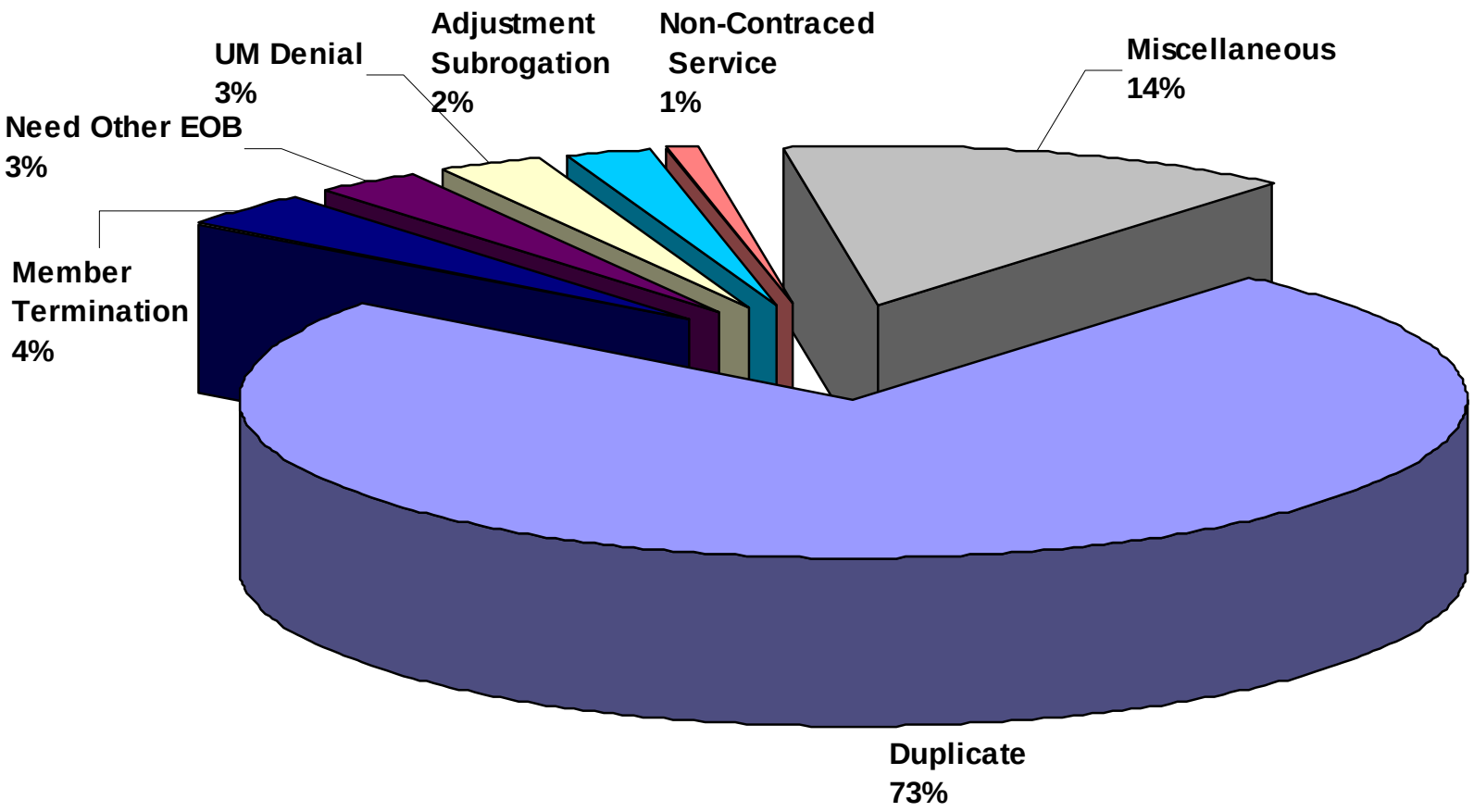
Top Denials - Commercial



* Commercial claims only

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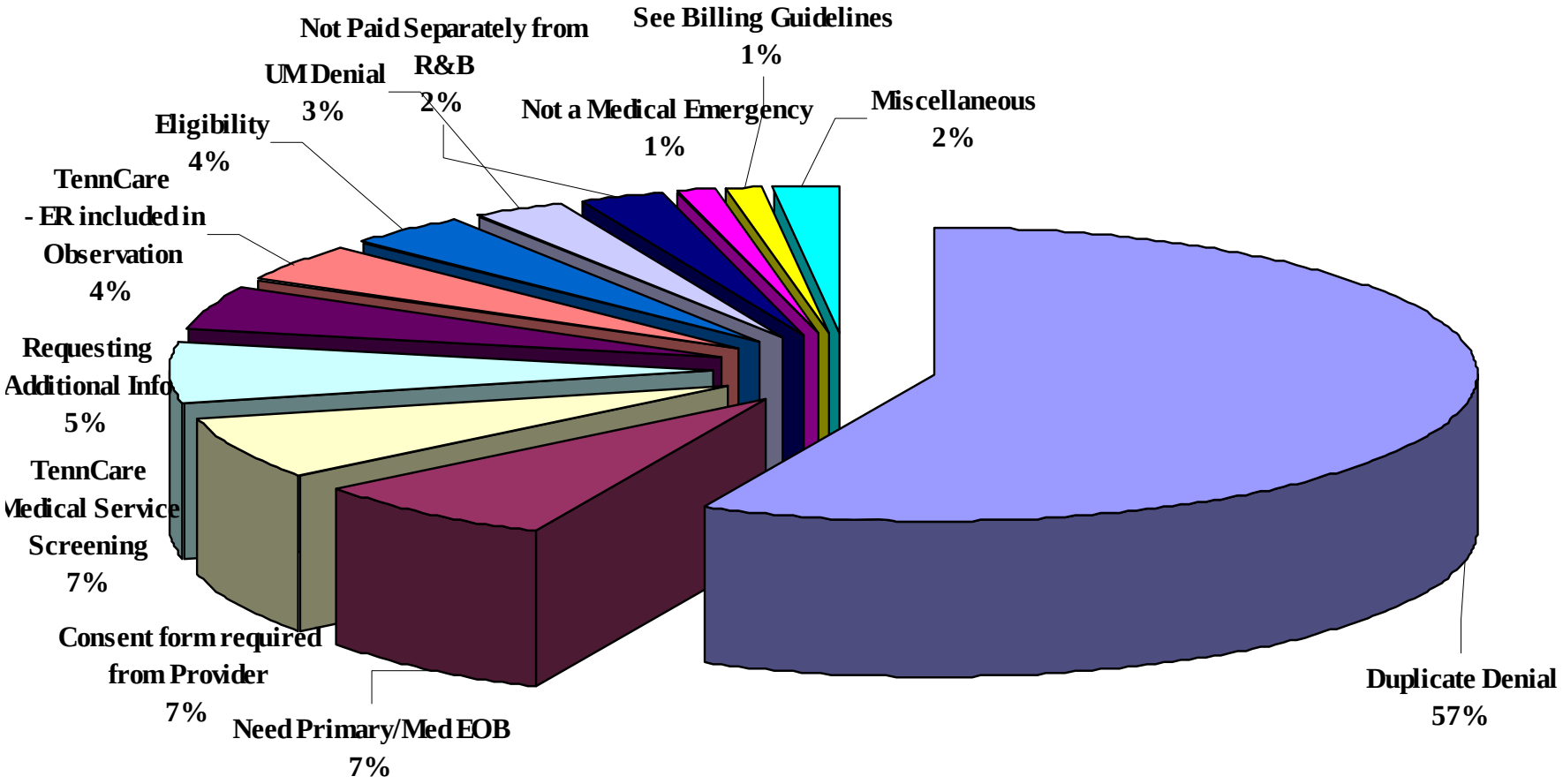
Top Denials - BlueCare



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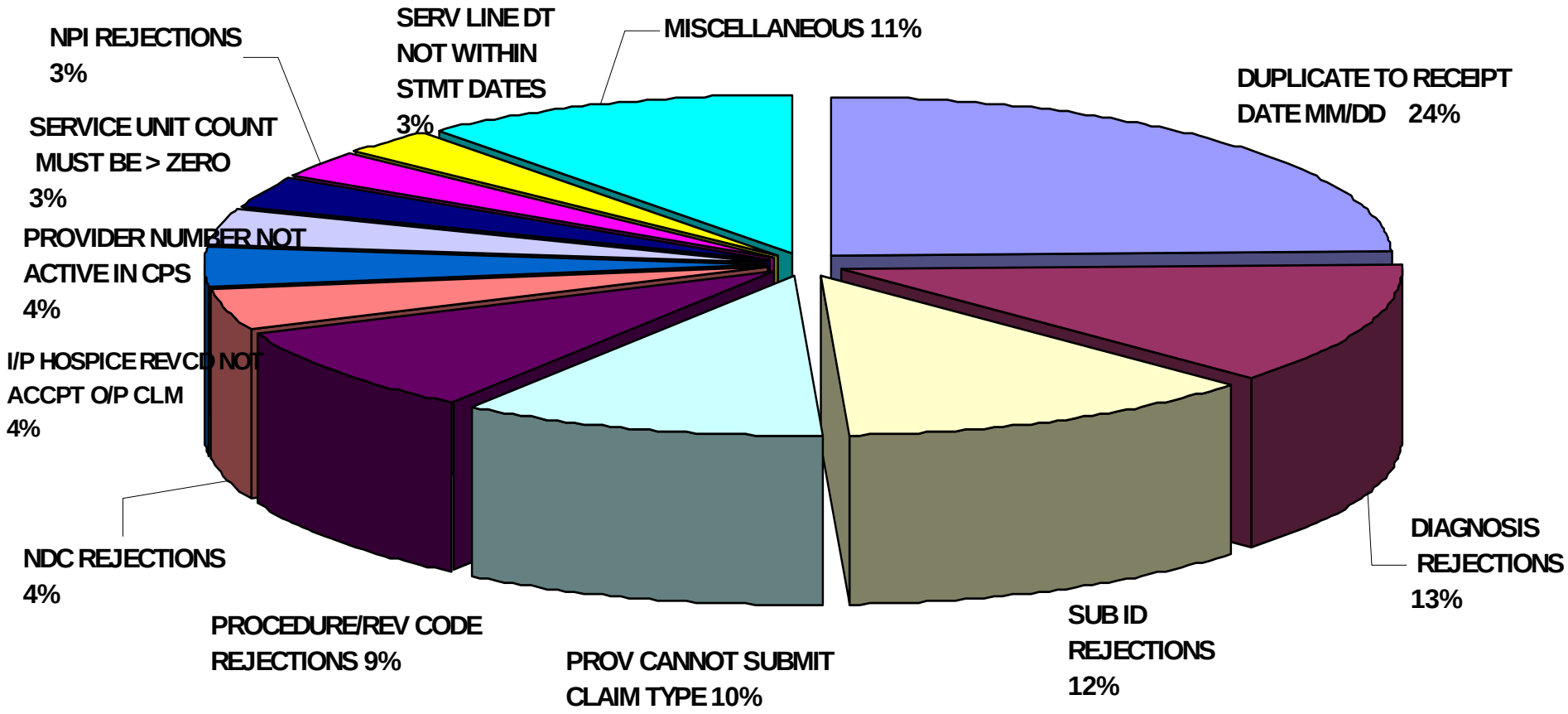
Top Rejects



* Include both Commercial and BlueCare

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Imaging Medical Records

- Imaging is the process of taking paper documents and scanning them to create electronic documents.
- Not all claims are imaged in our database.
- When sending requested medical records, only attach the letter or correspondence from BCBST (attaching the claim may cause a duplicate denial).
- When request for medical records is on your remittance, fax to Correspondence at 1-800-495-1944.
- If Correspondence does not pull the claim/records for review, it will remain in imaging.

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Scenario: Imaging Medical Records Rejects/Returns

Issue

You have submitted medical records multiple times and customer service cannot find them in imaging.

Reason for Rejection

- Medical records were filed with the original claim on top creating a duplicate reject.
- Medical records submitted without the BCBST letter attached resulting in misrouted records/document (Remittance denials should be sent to Correspondence with dispute form and remittance advice attached.)
- Medical records submitted in bundles can be scanned as one document resulting in lost records.

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Scenario: Imaging Medical Records Rejects/Returns

Issue

You have submitted medical records and customer service tells you they are “sitting in imaging.”

Reason for Rejection

Medical records will remain in imaging until the appropriate area pulls them for review. If your records have been sent in correctly, they will be routed and reviewed by the appropriate department as timely as possible.

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Billing Guidelines

The W26 explanation code incorporates several reasons for claim denials. Some of the reasons claims are denied with this code are:

- Unlisted procedure codes
- Invalid code combinations
- Outpatient services filed without the appropriate corresponding procedure code

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Scenario: Billing Guidelines

Issue

Services billed with revenue code 0360 operating room service, and procedure code 99284.

Reason for Rejection

The claim was billed with a procedure code that is not billable with revenue code 0360.

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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

- **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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Non-contracted Services

Non-contracted services include, but are not limited to the following:

- Emergency room revenue code billed with procedure other than those specific codes listed in the Schedule II contract.
- Services requiring specific contract agreement such as wound care services.
- Rehab services billed under the acute care provider number.
- Outpatient services billed without the required procedure code.

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Scenario: Non-contracted Services

Issue

The claim was billed for Outpatient ER and denied W09 – Non-contracted Services.

Reason for Rejection

The claim was filed with revenue code 0450 and procedure code not listed in the providers contract.

Resolution

- Non-contracted denials can be a result of several issues.
- The most common being non-contracted procedures or services billed under the incorrect provider entity.

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Non-Covered Services

- TennCare

  Once Financial Responsibility Waiver is obtained Provider should file all claims for the services rendered.

- Commercial

  Contractual obligation to file claims for all legitimate services

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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

The claim was filed by an acute care facility with principle diagnosis code 29181-Alcohol withdrawal and was denied with explanation code X10 Not paid on Acute Care Hospital Agreement.

Reason for Denial

Any claim filed under the acute care provider number with a behavioral health diagnosis code will deny with remittance explanation code X10.

Resolution

- These denials may be reviewed for payment if the charges are related to a true medical service.
- Medical records may be needed to determine what component of the contract the charges should apply.
- Reconsiderations for payment should be submitted on the dispute form to the Provider Service Organization for review.

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

❖BlueCross BlueShield of Tennessee will make DRG assignment via Centers for Medicare and Medicaid Services (CMS) Based Grouper – version 24 purchased from a Third Party Software Vendor.

❖The DRG assignment will be based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, gender, and discharge status of the patient.

❖The base rate and relative weights in effect at the admission date are used to calculate the payment level.

[1] CMS-DRG - Centers for Medicare and 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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Code Bundling Rules

- Evaluate the accuracy and adherence of medical claims to accepted national standards. These rules are based on **code bundling** guidelines:
  - National Correct Coding Initiative (NCCI)
  - American Medical Association (AMA) coding guidelines
  - Centers for Medicare and Medicaid Services (CMS) guidelines
  - Guidelines published by medical societies/associations
  - BlueCross BlueShield of Tennessee clinical expertise
  - Coding and Clinical Rules
- 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 required
- 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 W73.

Resolution

-Review the code bundling section of the provider page on the company websites, 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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High-Tech Imaging

- MedSolutions, Inc.. administers the prior authorization program
- High-Tech Imaging prior authorization is required for:
  - MRI/MRA/MRS
  - CT/CTA, PET
  - Nuclear cardiac imaging studies

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High Tech Imaging

Services not subject to authorization:

- Services performed in conjunction with an ER visit
- Mammography
- Inpatient Radiology Services
- Outpatient Radiology Services related to an inpatient stay
- Radiation Therapy Services

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Financial Recovery Administration (FRA)

- One Stop Shop for Recovery Information
- Identify Root Cause and Offer Advice to Prevent Recurrences
- Provide Better Feedback for Clinical Edit Error Situations
- Opportunity to be assigned a Personal Recovery Coordinator to Assist with Recovery Efforts
- Expansion and Resolution Efforts
- All Lines of business
- Unsolicited Overpayments and Solicited Overpayments

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Questions?

1. Ask now

2. Visit the Resource Centers

3. Call Provider Service

- Commercial	1-800-924-7141
- BlueCare	1-800-468-9736
- TennCare*Select*	1-800-276-1978
- BlueCard	1-800-705-0391
- BlueAdvantage	1-800-841-7434