

THE COMMONWEALTH OF MASSACHUSETTS

Report to the Massachusetts Division of Insurance

*Report on the Targeted Market Conduct Examination of
the Readiness of*

**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
and
Blue Cross and Blue Shield of Massachusetts, Inc.**

Quincy, Massachusetts

For Compliance with M.G.L. c. 176O §5A

For the Period September 1, 2011 through December 31, 2011

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June 24, 2012

Joseph G. Murphy
Commissioner of Insurance
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts 02118-6200

Dear Commissioner Murphy:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4 and Chapter 176G, Section 10, a targeted examination has been made of the market conduct affairs of

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
and
Blue Cross and Blue Shield of Massachusetts, Inc.

at its office located at:

**One Enterprise Drive
Quincy, Massachusetts**

The following report herein is respectfully submitted.

PURPOSE AND SCOPE OF THE EXAMINATION

Under authorization of the Division of Insurance (“Division”), pursuant to M.G.L. c. 175, § 4 and M.G.L. c. 176O, § 10 a targeted market conduct examination of Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. and Blue Cross and Blue Shield of Massachusetts, Inc. (collectively known as the “Company” or “Blue Cross”) was performed by Examination Resources, LLC (ER). The scope period of this examination was September 1, 2011 through December 31, 2011 (“Examination Period”). The onsite examination began March 5, 2012 and ended March 15, 2012. An additional visit was conducted by ER’s Informational Technology (IT) Specialist on March 27, 2012.

The purpose of the examination was to determine the status of the Company’s compliance with M.G.L. c. 176O, § 5A, which requires insurance carriers to accept and recognize patient diagnostic information and patient care service and procedure information submitted pursuant to, and consistent with, the current Health Insurance Portability and Accountability Act (“HIPAA”) compliant code sets; the International Classification of Diseases (“ICD”); the American Medical Association’s Current Procedural Terminology (“CPT”) codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (“HCPCS”). Section 5 further requires insurance carriers to adopt the aforementioned coding standards and guidelines, and all changes thereto, in their entirety, which shall be effective on the same date as the national implementation date established by the entity implementing the coding standards. The examination also included review of the claims forms in use by the Company to determine if the Company uses the standardized claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the HIPAA.

In addition, the examination included a review of the Company’s response to the required status reports pursuant to M.G.L. c. 176O, § 5A, which requires insurance carriers to submit quarterly detailed status reports of their compliance with certain identified coding issues. The coding issues are those issues for which compliance is required by M.G.L. c. 176O, § 5A, and as agreed upon by the Advisory Committee created by Chapter 305 of the Acts of 2008. For purposes of this examination, the status report submitted by the Company on November, 15, 2011 was reviewed by the examiners. In addition, the Company provided for review the most recent version of its compliance report, as of February 15, 2012.

In reviewing materials for this examination report, the examiners relied on records provided by the Company and personal observation by the examiners of processes and controls during the onsite examination. Testing was performed on both a sample basis and total population review on certain codes and/or modifiers, when feasible.

The National Association of Insurance Commissioners (“NAIC”) Market Analysis Handbook allows the utilization of Audit Command Language (“ACL”) for determining sample sizes and sampling. The 2011 version of the handbook was used. Samples sizes for this examination were calculated by entering a Confidence Level of 95%, an Upper Error Limit of 5% and an Expected Error Rate of 2%. ACL returned a sample size of 184 for the claims review.

EXECUTIVE SUMMARY

This summary of the targeted market conduct examination of the Company is intended to provide a high-level overview of the examination results. The body of the report provides details of the scope of the examination, tests conducted, findings, observations, recommendations and, if applicable, subsequent Company actions.

The examination included three areas of review: Processes and Controls, Review of Chapter 305 – Payer-Provider Coding Status Report and a Claims Sample Review.

The following is a summary of all substantive issues found, along with related recommendations and, if applicable, subsequent Company actions made, as part of the examination.

I. Processes and Controls

The review of the processes and controls along with the sample of the claims review and total population review of certain codes indicates that system edits are working as expected and processes and controls are appropriate. The review of the Company's processes and controls required the use of an Information Technology ("IT") Specialist. The work performed by the IT Specialist included an analysis of a questionnaire completed by the Company, conducting interviews of key personnel, performing walkthroughs of the Company's systems, and assisting the examiners, as deemed necessary. There are a few system enhancements that are being re-tested at the end of April 2012 to ensure full compliance with the uniform coding requirements.

II. Chapter 305 – Payer-Provider Coding Status Report

Review of the Company's responses to each listed issue along with the sample of the claims review and/or review of the total population for a given code within the data file (6,052,269 claim line records) showed that the Company's responses were accurate.

There are a few system enhancements that are being re-tested at the end of April 2012 to ensure full compliance with the uniform coding requirements. The Company explained there is a delay in auto adjudication of claims with multiple diagnostic codes. Although scheduled for Q4 2011, a bug in coding was identified during the post implementation review in August 2011. As a result, for claims currently processed through NASCO (25% of all claims), only the first diagnostic code is read and processed automatically. Claims with additional codes are routed for manual review and adjudication. The presence of multiple diagnostic codes does not result in a rejection though. The Company has indicated that enhancements to provide full compliance through auto-adjudication are on schedule for June 2012 implementation. It is the opinion of the

examiners that the Company's planned enhancements are expected to bring the Company into compliance by July 1, 2012.

With respect to the questions about the use of Modifier 51, which is not to be used in facility claims, it was found that the Company's system ignores the modifier when submitted by a facility provider, but it stores the modifier in the system to process the claim payment. Although this does not impact the payment of claims, it affects the accuracy and integrity of the data stored in the Company's system for reporting purposes.

III. Claims Sample Review

The claim files reviewed included a total of 629 CPT/HCPCS codes, 132 Modifiers and 296 ICD codes. There were no exceptions noted.

EXAMINATION RESULTS

I. Processes and Controls

The Electronic Data Interchange ("EDI") support team is responsible, with IBM, for receipt of electronic claims files, HIPAA compliance editing, reporting, provider outreach, and production support of EDI input related issues.

The Company stated that in 2011 it received about 92.7% of claims electronically. These are broken down as follows:

- Professional Claims – 93.9%
- Institutional Claims – 96.3%
- Dental Claims – 47.5%

Submissions are made by providers using different channels:

- Direct – Submissions of a HIPAA standard 837 claim file via secure SFTP or HTTPS to a secure Tumbleweed server with dedicated and secure individual folders for each submitter.
- Envoy Clearinghouse – Submission of a HIPAA 837 claim file via secure NDM connection.
- "Crossover" Claims – Submission of a HIPAA standard 837 claim file via secure NDM connection from Medicare Intermediaries.
- InterPlan Claims – Submission of a proprietary InterPlan format via secure InterPlan platform.
- On-line Data Entry – Professional providers can directly data enter their claims on the secure side of BCBSMA provider portal.

The Company processes approximately 50 million claims a year. Claims have been processed in two systems. EDS Total Plan System (TPS) and NASCO Processing System (Blue Cross nationwide network system). TPS is scheduled to be retired in 2013,

at which time all claims will be processed via NASCO. As a nationwide claims system, NASCO development is governed by a consortium of Blue Cross companies that jointly provide financial and other resources for its compliance projects. The Company has made numerous enhancements to the systems to ensure compliance with coding requirements. The Company stated that the TPS system enhancements have been completed and is fully compliant. The NASCO application code will not be fully re-tested until the end of April 2012. Enhancements to provide full compliance through auto-adjudication are on schedule for June 2012 implementation. It is the opinion of the examiners that the Company's planned enhancements are expected to bring the Company into compliance by July 1, 2012.

Data Capture/Scanning Processes (Paper Claims)

Data Capture teams are responsible for controlling mail receipt, bundling, system activation, scanning and system entry of paper claims and paper documents (e.g., member enrollment applications, service delivery correspondence).

Paper claims received by mail are sent to the Data Capture/Scanning Operations area where several scanning machines are in use by the Company. Operators work in pairs and the number of operators that are assigned is based on the volume of claims being processed. Typically, Monday is the day of the week with the largest number of claims to scan, which the company has indicated can reach as many as 40,000 claims.

In another room in this area, there are operators whose responsibility is to ensure the documents are scanned properly and labeled correctly. The operators also ensure that OCR software properly reads the documents, so the captured data goes into the system correctly. The system automatically flags scanned documents with potential errors and these are corrected manually.

Claims Edits

The Company provided a list of its system edits and one of the operators demonstrated the way the edits work. A couple of claims were looked up in the system and changes were made to CPT codes and ICD codes and it was observed how the system would reject a claim with an invalid code.

Claims Quality Assurance Program

The Company has established a Quality Assurance Program where claims are audited prior to payment on a daily basis. The Data Capture/Scanning area is also audited on a daily basis. The process focuses on high dollar claims where all claims that were manually processed with a \$5,000 or higher payment are all reviewed. Any First Pass claim and adjustments totaling over \$50,000 are also reviewed. For lower dollar claims, random samples of claims are reviewed. The Company stated that their Quality Assurance reviews showed the following:

- Financial Accuracy – 99.4%
- Payment Accuracy – 99.3%
- Procedural Accuracy – 98.4%

The IT Specialist also reviewed the Company's SSAE16 testing and documentation performed by Ernst & Young, LLP. The SSAE16 is published annually for the benefit of the Company's clients who receive claims processing services. The IT Specialist reviewed the SSAE16 noting that controls cover the claims/payment process in detail and that there appears to be no significant control weaknesses as of December 31, 2011.

II. Chapter 305 – Payer-Provider Coding Status Report

The quarterly detailed status report of the Company's compliance with certain identified coding issues, submitted as of November 15, 2011, was reviewed. The Company also provided the latest version of that report, as of February, 15, 2012, to the examiners.

The responses to each issue listed were reviewed and testing was performed either on a sample basis (claims sample review), review of the total population of a given code within the data files provided by the Company, or both. To augment the examiners' ability to confirm all responses, the participation of an IT Specialist was deemed necessary for this examination.

Issue 1

Bilateral procedures (Modifier 50) - There are concerns that certain payers will not accept the Bilateral Modifier 50 and require that the CPT Code be listed twice.

Company Response: The Company stated "standard coding applies for professional and institutional claims."

Testing: The selected sample did not include any claims with Modifier 50, however, review of the total population for this code within the data file shows 7,623 claims where Modifier 50 was used; therefore, the Company does allow and recognizes Modifier 50.

Results: No exceptions were noted.

Issue 2

Multiple Procedures (Modifier 51) (Physician Practice vs. Facility) - Per CPT coding conventions, this modifier should only be used for physician practices. There are concerns that certain payers have medical policies that do not distinguish this and may instruct hospitals to report Modifier 51 which is not for use in the hospital setting.

Company Response: The Company stated “standard coding applies for professional.”

Testing: The selected sample did not include any claims with Modifier 51. However, review of the total population for this code within the data file showed 197 facilities records using Modifier 51. The Company stated “it does not require facilities to use this modifier, but it does not reject claims that are submitted. The system is set to ignore Modifier 51 when processing facilities claims.” The IT Specialist performed further review of Modifier 51. Blue Cross elaborated, explaining that the system change implemented on December 23, 2011 allowed the ability to recognize modifiers in any of three positions in both the TPS and NASCO claims. In the modifier examples, including Modifier 51, the payment remains consistent regardless of where the modifier was placed. Blue Cross also stated “since Modifier 51 is professional only, the Company applies processing logic when received on a professional claim.” However, as stated before, when a facility provider submits a claim with Modifier 51, the modifier is ignored by the system, but keeps the modifier stored as submitted.

Results: The system accepts the incorrect modifier, but is not being used to process the claim. This approach is not consistent with coding conventions and may affect the accuracy and integrity of the data stored in the Company’s system for reporting purposes.

Issue 3

Reduced Services (Modifier 52) - There are concerns that certain payers require use of Modifier 73/74, and vice versa, for incomplete or reduced colonoscopy procedures (Physicians).

Company Response: The Company stated “standard coding applies for professional and institutional.”

Testing: The selected sample did not contain any claims with Modifiers 73/74, however, review of the total population for this code within the data file shows 75 claims using Modifiers 73/74, and of those, 6 were Professional claims and none were related to colonoscopy procedures.

Results: No exceptions were noted.

Issue 4

Distinct Procedures (Modifier 59) - There are concerns that certain payers vary in their instruction/recognition of Modifier 59 and do not clearly communicate any pertinent payment reduction/considerations to the providers.

Company Response: The Company stated “it accepts and recognizes three facility modifiers as of June 17, 2011. However, Modifier 59 must be in the first position. A system change was implemented in 4th Quarter of 2011 to allow Modifier 59 to be in any field.”

Testing: None of the selected sample and claims included in the data file reflected the changes due to the late implementation. The IT Specialist observed a demonstration of a claim with Modifier 59 in various positions of a claim, including line 2. In all positions, the claim was auto adjudicated and populated with a code "PO17" meaning it will be paid.

Results: No exceptions were noted.

Issue 5

Repeat Clinical Diagnostic Lab Test (Modifier 91) - There are concerns regarding confusion associated with criteria to be used in the application of Modifier 91 and that certain payers do not recognize that Modifier 91 is to be used only for repeat lab tests and not other diagnostic test CPT code ranges.

Company Response: The Company stated “it accepts and recognizes three facility modifiers as of June 17, 2011. However, Modifier 91 must be in the first position. A system change was implemented in 4th Quarter of 2011 to allow Modifier 91 to be in any field.”

Testing: The selected sample did not contain any claims with Modifier 91. Review of the total population for this code within the data file shows that Modifier 91 is accepted and recognized by the Company. A further review showed that when used, it was for repeat laboratory tests.

Results: No exceptions were noted.

Issue 6

Accepting multiple modifiers on the same line - There are concerns that payers vary in accepting the number of modifiers on the same line - some allow 2, 3 or 4. There are concerns that despite allowing more than one modifier on a line, certain payers only recognize the first modifier.

Company Response: The Company stated “it accepts and recognizes three facility modifiers as of June 17, 2011. However, Modifiers 25, 59, and 91 must be in the first position. A system change was implemented in 4th Quarter 2011 to allow all modifiers to be in any field.”

Testing: The selected sample showed the use of multiple modifiers in the same line. In addition, the IT Specialist observed a demonstration of claims with Modifiers 25, 59 and 91 in various positions of a claim. In all cases except as noted below, the claim payment code was "PO17" meaning that the modifier is accepted and the claim will be paid. During the demonstration, management stated that per the ICD manual, Modifier 91 should be in the first position. However, if Modifier 91 is in the 2nd position it is still recognized. When Modifier 91 was entered in the 3rd position, the payment code changed to P600, meaning it would be suspended for manual review (but not denied). Backend audits are performed monthly and include 100% of Modifier 91 claims to ensure that manual procedures are followed.

Results: No exceptions were noted.

Issue 7

V76.0-V76.9 - Screening for Malignant Neoplasm - There are concerns that for certain payers multiple claims are rejected because the V code is sequenced first, and that Information Systems ("IS") issues exist for certain payers that are unable to screen secondary diagnostic codes.

Company Response: The Company stated "systems issues have been resolved and implemented in production coding to allow approximately 75% of claims to read all diagnosis submitted for medical necessity. Remaining coding expected to be resolved by the end of 2nd quarter 2012."

Testing: The selected sample did not include claims with V76x codes. The IT Specialist determined that for the two claims systems in use, TPS (local networks) and NASCO (Blue Cross nationwide network system), TPS is now compliant but the NASCO application code will not be fully re-tested until the end of April 2012. The Company explained that full compliance requires reloading of all (3,500) user configuration tables. User configuration tables are not centralized and must be loaded at each office location. The table updates are normally tied to renewals because plans and coverage change each year. The Company would have been compliant once all renewals for 2012 were in place. To accelerate compliance, the updated tables are being rolled out in phases and the project will be completed by July 2012. Until then, certain CPT codes will generate a "suspend" state requiring manual review. However no claims will be automatically rejected.

Results: The Company should provide an update to the Division once this issue has been resolved.

Issue 8

V57.0-V57.9 - Encounter for Rehabilitation. Services - There are concerns that certain payers will not accept the correct V Code sequencing (1st Listed) for Rehabilitation encounters and instruct providers to incorrectly sequence a medical condition first for Rehabilitation Therapy or Services.

Company Response: The Company stated “it accepts and recognizes codes V57.0-V57.9. Reimbursement for these codes is based on the member's benefit.”

Testing: There were no claims with ICD code V57.x in the selected sample, however, the IT Specialist observed the automated adjudication on actual claims containing V57 codes. Several claims were shown with dates ranging from 8/20/11 to 1/03/12. All claims had a payment code of PO17, meaning it would be paid automatically. However, claims with certain CPT codes will generate a "suspend" state requiring manual review. However, it appears from the review that no claims will be automatically rejected.

Results: The Company should provide an update to the Division once this issue has been resolved.

Issue 9

V67.0-V67.9 - Follow-up Examinations - There are concerns that certain payers instruct providers to omit the V code and list the code for the original condition or injury – even if resolved.

Company Response: The Company stated “it accepts and recognizes codes V67.00-V67.9. Reimbursement for these codes is based on the member's benefit.”

Testing: There were no claims with ICD code V67.x in the selected sample, however, the IT Specialist observed the automated adjudication on actual claims containing V67.59 and 67.2. Three claims were observed from 1/2012, 6/2011, and 6/2010. All the noted claims had a payment code of PO17, meaning it was paid automatically.

Results: No exceptions were noted.

Issue 10

V51-V58.9 - Encounter for Aftercare - There are concerns that certain payers do not process claims with this range of codes and instruct providers to submit the code for the initial injury or illness in the first position in order to process the claim. Some Specific Aftercare V Codes within this range that trigger edits: V51-Plastic Surgery – Aftercare;

V54.81-V54.9 – Orthopedic Aftercare; V58.0-Encounter for Radiation Therapy; V58.1-Encounter for Chemotherapy; V58.61-V58.61 – Long-term current use of medications (i.e. coumadin); V55.3 –Attention to Colostomy- (i.e. Closure).

Company Response: The Company stated “it accepts and recognizes codes V51-V58.9. Reimbursement for these codes is based on the member's benefit.”

Testing: The selected sample and review of the data file showed that these codes are accepted and recognized.

Results: No exceptions were noted.

Issue 11

V30.00-V39.20 - Liveborn Infants - There are concerns that certain payers instruct providers to omit the V code as the first listed code on claims forms.

Company Response: The Company stated “it accepts and recognizes diagnosis range.”

Testing: The selected sample and review of the data file showed that these codes are accepted and recognized.

Results: No exceptions were noted.

Issue 12

V04.8 –Flu; V05.9 – Viral; V06.5-Tetanus Vaccinations - There are concerns that certain payers rejecting claims for these codes with error message: Diagnosis incorrect for reimbursement.

Company Response: The Company stated “it accepts and recognizes codes V04.8 –Flu; V05.9 – Viral; V06.5. Reimbursement for these codes is based on the member's benefit. Some member contracts do not provide routine benefits.”

Testing: The selected sample and review of the data file showed that these codes are accepted and recognized.

Results: No exceptions were noted

Issue 13

Contraceptive V25.09-Mgt; V25.41-BCP Surveillance; V25.49-Surveillance - There are concerns that certain payers reject claims with the error message: Diagnosis incorrect for reimbursement.

Company Response: The Company stated “it accepts and recognizes codes V25.09-Mgt; V25.41-BCP Surveillance ; V25.49-Surveillance. Reimbursement for these codes is based on the member's benefit. Some member contracts do not provide routine benefits.”

Testing: The selected sample did not contain any claims with ICD codes V25x. However, the IT Specialist observed the claim system demonstration showing codes V25.09 and V25.41 being accepted and recognized.

Results: No exceptions were noted.

Issue 14

V72.8x –Other Specified Exams - There are concerns that certain payers reject claims with first listed diagnosis of V Code for the Examination. Instructions are given to submit a medical condition (acute or chronic) rather than the V Code.

Company Response: The Company stated “it accepts and recognizes code V72.8x. Reimbursement for this code is based on the member's benefit. Some member contracts do not provide routine benefits.”

Testing: The selected sample and review of the data file showed that these codes are accepted and recognized.

Results: No exceptions were noted.

Issue 15

Timely ICD-9, CPT-4, HCPCS updates in system - There are concerns that providers are looking for the actual dates that the codes are adopted and the actual dates they are implemented/used for claims processing.

Company Response: The Company stated “its policy is to accept all new CPT codes by January 1st annually and accept new ICD-9 by October 1st annually.”

Testing: The Company provided evidence that updates were tested and installed in October 2011 for diagnostic codes and in January 2012 for procedure codes. Procedure codes are updated quarterly but January 2012 is the largest update.

Blue Cross also explained that full compliance requires reloading of all user configuration tables. User configuration tables are location specific and are tied to renewals as the plans change each year. As such, the updated tables are being rolled out in phases and the project will be completed by July 2012. Until then, certain CPT codes will generate a "suspend" state requiring manual review. However no claims will be automatically rejected.

The IT Specialist also reviewed the related change management process as described in the BCBSMA SSAE16.

Results: No exceptions were noted.

Issue 16

Physical Therapy ("PT")/Occupational Therapy ("OT") evaluation versus initial evaluation - PT and OT share many of the same CPT codes. Standard coding guidelines requires modifiers, but there are concerns that certain payers do not allow them and are also requiring inappropriate use of CPT codes by requiring OT to be billed using Evaluation or Re-Evaluation CPT codes, instead of the actual modalities that were performed.

Company Response: The Company stated "standard coding applies for professional claims. System change was implemented effective January 1, 2012 for institutional."

Testing: The IT Specialist confirmed that presently PT claims are recognized with modalities. Management also explained that per the patient contracts, a single fee is paid for physical therapy regardless of additional PT/OT procedures. However the additional procedures are read and captured.

Results: No exceptions were noted.

Issue 17

Canceled Procedures – V Code and Modifiers - Institutional Claims: Modifiers and ICD-9 codes exist to reflect cancellation of planned procedures. There are concerns that certain payers do not have clear-cut payer policies and recognition of modifiers to promote consistent capture and claims processing.

Company Response: The Company stated “it accepts and recognizes V codes and modifiers for canceled procedures.”

Testing: Review of the data file indicates acceptance and recognition of canceled procedure codes and Modifiers 52, 53, 73 and 74.

Results: No exceptions were noted.

Issue 18

Canceled Procedures – V Code and modifier – Physician - Modifiers and ICD-9 codes exist to reflect cancellation of planned procedures. There are concerns that certain payers do not have clear-cut payer policies and recognition of modifiers is needed in order to promote consistent capture and claims processing.

Company Response: The Company stated “it accepts and recognizes V codes and modifiers for canceled procedures.

Testing: Review of the data file indicates acceptance and recognition of canceled procedure codes and Modifiers 52, 53, 73 and 74.

Results: No exceptions noted.

Issue 19

Total Number of diagnosis accepted and/or recognized - Institutional Claims - There are concerns that there is variation in the number of outpatient diagnostic codes accepted and recognized by certain payers.

Company Response: The Company stated “it accepts up to nine diagnoses on a facility outpatient claim. However, for medical necessity recognizes five, for all other situations it recognizes one. For inpatient claims, the Company now accepts and recognizes admitting, primary, emergency/accident, and 24 secondary diagnoses. A system change was implemented at the end of the 4th Quarter of 2011 to read all diagnosis for medical necessity/policy on OPD claims.”

Testing: The Company stated “systems issues have been resolved and implemented in production coding to allow approximately 75% of claims to read all diagnosis submitted for medical necessity. Remaining coding expected to be resolved by the end of 2nd quarter 2012.” The IT Specialist determined that for the two claims systems in use, TPS (local networks) and NASCO (Blue Cross nationwide network system), TPS is now fully compliant, but the NASCO application code will not be fully re-tested until the end of April 2012. The Company explained a delay in auto adjudication of claims with multiple

diagnostic codes. Although scheduled for Q4 2011, a bug in coding was identified during post implementation review in August 2011. As a result, for claims currently processed through NASCO (25% of all claims), only the first diagnostic code is read and processed automatically. Claims with additional codes are routed for manual review and adjudication. The presence of multiple diagnostic codes does not result in rejection though. Enhancements to provide full compliance through auto-adjudication are on schedule for June 2012 implementation.

Results: The Company should provide an update to the Division once this issue has been resolved.

Issue 20

Total Number of diagnosis accepted and/or recognized - physician level claims - There are concerns that there is variation in the number of outpatient diagnostic codes accepted and recognized by certain payers.

Company Response: The Company stated “it accepts up to four diagnosis code on the HCFA1500 paper claim and all available on the 837P HIPAA transaction.”

Testing: The Company stated “systems issues have been resolved and implemented in production coding to allow approximately 75% of claims to read all diagnosis submitted for medical necessity. Remaining coding expected to be resolved by the end of 2nd quarter 2012.” The IT Specialist determined that for the two claims systems in use, TPS (local networks) and NASCO (Blue Cross nationwide network system), TPS is now fully compliant, but the NASCO application code will not be fully re-tested until the end of April 2012. The Company explained a delay in auto adjudication of claims with multiple diagnostic codes. Although scheduled for Q4 2011, a bug in coding was identified during post implementation review in August 2011. As a result, for claims currently processed through NASCO (25% of all claims), only the first diagnostic code is read and processed automatically. Claims with additional codes are routed for manual review and adjudication. The presence of multiple diagnostic codes does not result in rejection though. Enhancements to provide full compliance through auto-adjudication are on schedule for June 2012 implementation.

Results: The Company should provide an update to the Division once this issue has been resolved.

Issue 21

Medical Necessity Denials and Rejections - Code Recognition: Claims Denials and Rejections. There are concerns that certain payers are not consistently reading or

recognizing additional 2nd, 3rd, 4th listed diagnoses codes pre-determined and documented medical necessity for the plan(s).

Company Response: The Company stated “system change was in process to read all diagnoses when determining medical necessity for OPD claims, for inpatient it currently reads 25 diagnoses. Change to read all OPD diagnosis was initially targeted for end of 4th Quarter of 2011.”

Testing: The Company stated “systems issues have been resolved and implemented in production coding to allow approximately 75% of claims to read all diagnosis submitted for medical necessity. Remaining coding expected to be resolved by the end of 2nd quarter 2012.” The IT Specialist determined that for the two claims systems in use, TPS (local networks) and NASCO (Blue Cross nationwide network system), TPS is now fully compliant, but the NASCO application code will not be fully re-tested until the end of April 2012. The Company explained a delay in auto adjudication of claims with multiple diagnostic codes. Although scheduled for Q4 2011, a bug in coding was identified during post implementation review in August 2011. As a result, for claims currently processed through NASCO (25% of all claims), only the first diagnostic code is read and processed automatically. Claims with additional codes are routed for manual review and adjudication. The presence of multiple diagnostic codes does not result in rejection though. Enhancements to provide full compliance through auto-adjudication are on schedule for June 2012 implementation.

Results: The Company should provide an update to the Division once this issue has been resolved.

Issue 22

Medical Necessity Denials and Rejections: Policy Coverage Logic - There are concerns that certain payers have 1. Payer Guidelines that fail to recognize official coding guidelines by requiring 1st listed/primary codes that are vague and/or should never be used as 1st listed diagnostic codes (examples: Late effect 900 codes) 2. Incorrect ICD-9-CM diagnostic codes were listed by the payer for coverage. Failure of the payer to recognize the correct diagnoses codes (example: authorizing coverage for 996.52 complications for skin grafts vs. amputation flap complication code category range). 3. Policy Coverage Language that ensures coverage for high risk/family history conditions but fails to recognize Official Sequencing Guidelines for codes submitted. In other words, recognizes 1st listed code only.

Company Response: The Company stated “it is compliant and recognizes UB04 and HIPAA code sets, as well as official ICD-9-CM diagnosis code set.”

Testing: The Company stated “systems issues have been resolved and implemented in production coding to allow approximately 75% of claims to read all diagnosis submitted

for medical necessity. Remaining coding expected to be resolved by the end of 2nd quarter 2012.” The IT Specialist determined that for the two claims systems in use, TPS (local networks) and NASCO (Blue Cross nationwide network system), TPS is now fully compliant, but the NASCO application code will not be fully re-tested until the end of April 2012. The Company explained a delay in auto adjudication of claims with multiple diagnostic codes. Although scheduled for Q4 2011, a bug in coding was identified during post implementation review in August 2011. As a result, for claims currently processed through NASCO (25% of all claims), only the first diagnostic code is read and processed automatically. Claims with additional codes are routed for manual review and adjudication. The presence of multiple diagnostic codes does not result in rejection though. Enhancements to provide full compliance through auto-adjudication are on schedule for June 2012 implementation.

Results: The Company should provide an update to the Division once this issue has been resolved.

Issue 23

Medical Necessity Claims and Rejections: Outpatient Claims and Rejections - There are concerns that certain payers have 1. Medical Policy Language that Fails to Address Official Outpatient Coding Guidelines (example: Fetal Ultrasounds - Coverage Policy lists "coverage for suspected condition listing").

Company Response: The Company stated “it accepts up to nine diagnoses on the claim. For medical necessity it currently recognizes five, for all other situations it recognizes one. There is a system change in process to read all diagnoses for medical necessity/medical policy.”

Testing: The Company stated “systems issues have been resolved and implemented in production coding to allow approximately 75% of claims to read all diagnosis submitted for medical necessity. Remaining coding expected to be resolved by the end of 2nd quarter 2012.” The IT Specialist determined that for the two claims systems in use, TPS (local networks) and NASCO (Blue Cross nationwide network system), TPS is now fully compliant, but the NASCO application code will not be fully re-tested until the end of April 2012. The Company explained a delay in auto adjudication of claims with multiple diagnostic codes. Although scheduled for Q4 2011, a bug in coding was identified during post implementation review in August 2011. As a result, for claims currently processed through NASCO (25% of all claims), only the first diagnostic code is read and processed automatically. Claims with additional codes are routed for manual review and adjudication. The presence of multiple diagnostic codes does not result in rejection though. Enhancements to provide full compliance through auto-adjudication are on schedule for June 2012 implementation.

Results: The Company should provide an update to the Division once this issue has been resolved.

Issue 24

Unlisted CPT Procedure Codes - There are concerns that certain payers have 1. Payer Rejections and Mandates for Hospital to "Change" the Unlisted Code to closest/similar CPT Code due to Payer IS/ Processing Constraints and/or lack of Medical Review Policies pertaining to unlisted CPT Codes.

Company Response: The Company stated “standard coding applies and that it accepts unlisted codes with supporting documentation.”

Testing: The selected sample showed no claims were rejected based on unlisted codes in the sample review. The Company does require supporting documentation when a provider submits a claim with an unlisted code.

Results: No exceptions were noted.

Issue 25

Unlisted CPT Procedure Codes - Errors in Assignment (Payer and Provider) - Payer/Provider Audit Discrepancies. There are concerns about discrepancies with multiple Payer Rejections of Unlisted CPT Procedure Codes leading to manual re-review, manual appeal, manual re-submission of supporting documentation.

Company Response: The Company stated “standard coding applies and that it accepts unlisted codes with supporting documentation.”

Testing: The selected sample showed no claims were rejected based on unlisted codes in the sample review. The Company does require supporting documentation when a provider submits a claim with an unlisted code.

Results: No exceptions were noted.

Issue 26

Retrospective Diagnosis Related Groups (DRG) and CPT Audits (Inpatient and Outpatient Provider) – There were the following concerns for certain payers –

1. Payer/Provider Discrepancies. Multiple Rejections of Initial DRG Assignment leading to manual re-review, manual appeal, manual re-submission of supporting documentation.
2. Auditors fail to quote and/or ignore Official ICD-9-CM and CPT Code Set Guidelines.
3. High Appeal/Over-turn Rates Upon Re-Review (35-40%).
4. Escalating Administrative Costs Associated with Payer's Failure to Recognize Official Code Set Guidelines.

Company Response: The Company stated “its Auditors review medical records using official code set guidelines including: AHA Coding Clinic, AMA CPT Assistant, CMS/HCPCS Level II Guidelines.”

Testing: The selected sample review showed DRG Claims were handled properly.

Results: No exceptions were noted.

III. Claims Review

The Company provided a data file containing 6,052,269 claim line records. A total of 184 claims were randomly selected for review. The sample was reviewed to determine the Company’s acceptance and recognition of information submitted pursuant to current coding standards and guidelines required, as well as use of standardized claim formats.

The Company uses standardized claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the HIPPA.

The claim files reviewed included a total of 629 CPT/HCPCS codes, 132 Modifiers and 296 ICD codes.

Results:

No exceptions noted.

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Victor M. Negron, AIE, FLMI, and Ann McClain, CIE, FLMI, Joan McClain, AIE, FLMI and Michael Morrissey, AES, CISA, CISSP, participated in this examination.

Respectfully submitted,

Examination Resources, LLC