Independence
Blue Cross

PROVIDER BULLETIN

Bulletin #08-2010

TO: Participating hospitals and ambulatory surgical centers

FROM: Christopher E. McTiernan
Senior Director, Provider Reimbursement

DATE: August 20, 2010

SUBJECT: Fee schedule update and reminders for billing outpatient units of service and ER follow-up care

We are sending this bulletin to inform you of a fee schedule change and to notify you of several billing/payment issues.

FEE SCHEDULE UPDATE – CHEMOTHERAPY DRUG PAYMENTS

In response to provider feedback, we are moving CPT® code 36593 (declotting by thrombolytic agent of implanted vascular access device or catheter) from the surgical fee schedule to the chemotherapy fee schedule and revising the fee schedule rate effective October 1, 2010. The change of correlation and fee schedule for CPT code 36593 will allow chemotherapy-related drugs to pay separately when performed during the same encounter. Currently, the correlation of CPT code 36593 to surgery results in the drugs being bundled into the surgical case rate.

An updated correlation edits table and fee schedule changes document will be included with the 4th Quarter Billing Updates bulletin, which will be sent September 1, 2010.

INCORRECT BILLING OF OUTPATIENT UNITS OF SERVICE

We continue to identify and retract erroneous payment for outpatient claims being billed with incorrect units. These billing errors result in avoidable administrative expense for both Independence Blue Cross and our participating facilities. We identify incorrect billing of outpatient units based on the following methods:

- **CPT and HCPCS code definition.** Select codes are, by definition, limited to a maximum number of units for a single date of service. Claim lines with billed units that exceed such limits will be rejected on a pre- and/or post-payment basis.
- **Medically Unlikely Edits (MUE) from CMS.** Claim lines with billed units that exceed MUE limits from the Centers for Medicare & Medicaid Services (CMS) will be rejected on a pre- and/or post-payment basis. Additional information on MUEs can be found at www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp.

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We encourage you to share this information with appropriate members of your staff.

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- **Statistically aberrant billing patterns.** Provider unit-of-service billing patterns are continuously analyzed to identify aberrant billing patterns as compared to a peer group and/or a facility's historical billing practices for clinically similar claims. To the extent that aberrant billing patterns are identified, medical records may be requested and claim lines may be retrospectively adjusted if the billed units are found to be incorrect.
- **Injectable drugs, infusions, and radiopharmaceuticals.** For a limited number of codes, we use information from drug manufacturers to identify maximum dosage amounts per patient per date of service. For these select codes, claim lines with billed units that exceed such limits will be rejected or adjusted on a pre- or post-payment basis.

  For other select codes where dosage amounts vary based on clinical indications (e.g., patient height, weight, treatment plan), medical records may be requested and claim lines may be retrospectively adjusted if the billed units are found to be inconsistent with the medical record.

ER FOLLOW-UP CARE REMINDER

We have identified an increase in claims for follow-up care provided in an emergency room (ER) setting. Generally, follow-up care after an ER visit is considered routine care. Members should be referred by the ER to an appropriate primary or specialty care physician for any routine follow-up care, such as the removal of sutures and wound dressing. In addition, directing follow-up care back to the ER setting results in higher out-of-pocket costs for our members.

The following are examples of routine follow-up care that have been provided in an ER setting:

- Patient returns to have a prescription that was written in the ER extended.
- Patient returns to the ER for reapplication of bandages, splints, or wraps.
- Patient, who had a laceration repaired with sutures, returns to have the sutures removed.

Routine (non-emergent) follow-up care provided in the ER setting by a participating provider is not eligible for a separate ER visit payment. Payment for follow-up care provided in the ER shall be considered included in the payment to the participating provider for the initial ER visit.

Additional information on ER services can be found on the NaviNet® web portal in the current version of the *Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers* and *Provider Manual for Participating Professional Providers.*

If you have any questions about this bulletin, please contact your Network Coordinator.

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