AMERICAN OSTEOPATHIC ASSOCIATION

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March 20, 2018

Opella Ernest, MD
Senior Vice President & Chief Clinical Officer
Health Care Service Corporation
300 East Randolph St.
Chicago, IL 60601

Dear Dr. Ernest:

On behalf of the American Osteopathic Association (AOA) and the nearly 140,000 osteopathic physicians (DOs) and medical students that we represent, I am writing in regards to code-auditing enhancements that were implemented late last year across Health Care Service Corporation's (HCSC) plans in Illinois, Montana, New Mexico, Oklahoma and Texas.

According to information released in August 2017 to providers in HCSC's networks, updates were made to plans' software and systems to help improve auditing of professional and outpatient facility claims. Additionally, clinical validation protocols were instituted for modifiers submitted on such claims. Since implementation of these measures, the AOA has received numerous complaints from physicians practicing in a variety of medical and surgical specialties regarding the lack of provider information, engagement and education on the above-referenced software/system updates and validation protocols.

Further, a significant and growing number of physicians and other clinicians within HCSC's networks have reported a sharp rise in automated denials of initial Evaluation and Management (E/M) services claims appended with modifiers 25 or 59, despite the fact that the claims in question adhere to your plans' policies and nationally accepted and sourced guidelines (e.g., Current Procedural Terminology [CPT] rules, National Correct Coding Initiative [NCCI] edits). The AOA strongly objects to the automatic denial of any claims for covered, medically necessary services without the provider first receiving a timely, succinct request for clinical documentation and the performance of a review of the submitted records by a trained, qualified auditor.

The AOA shares HCSC's concerns with respect to the rising cost of health care and recognizes the importance of payors' fraud, waste, and abuse prevention and detection processes. However, as a member-focused organization, we oppose any activities or cost-containment initiatives that place an undue administrative burden on physicians and create a barrier for patients to access and receive high-quality, medically necessary care at the appropriate time and in the appropriate setting. With that said, we strongly believe that there must be consistent messaging and an open line of communication between HCSC, its plans and contracted providers regarding the scope and duration of this review, as well as informational transparency on the validation methods employed by reviewers and the appeals processes afforded clinicians. The AOA would certainly be pleased to facilitate an enhanced communication process with our member base.

In order to serve our members, we are requesting written responses to the questions set forth in the enclosed document. Additionally, to further detail our concerns, we are also requesting a face-to-face meeting, to include the appropriate individuals from your organization, the AOA and state osteopathic medical associations in the impacted states, as soon as possible. I have asked the AOA's Physician Services & Payor Relations team to follow up with your office to schedule that meeting at your convenience.

Thank you for your consideration and your commitment to providing support to contracted DOs that are providing high-quality, patient-centered care to HCSC's members. I look forward to receiving responses to the attached questions and connecting in-person in the near future.

Sincerely,

Mark A. Baker, DO
President, Board of Trustees

Enclosure: "AOA Questions for HCSC"

Enclosure – AOA Questions for HCSC

1. What modifiers are in scope for each plan's edit? Are all Level I (CPT-4) modifiers included? Are any Level II (non-CPT-4 alpha numeric) and/or Level III (local) modifiers in scope for this review?

2. What types of health insurance products are impacted by this review? Is it true that the enhancements apply only to claims submitted for fully-insured commercial plans in the individual, small group and large group markets?

3. Are all E/M claims with in-scope modifiers (see question #1) automatically denied upon initial submission for all providers? If no, have certain providers and/or specialties been pre-screened and flagged for review based on potential aberrancies in billing patterns and/or statistical variances from normative data?

4. Are all denied claims appended with the in-scope modifiers (see question #1) subjected to a "clinical validation" edit by a trained reviewer? If yes, what is the process once a claim has been denied or flagged for review?

5. How does each plan assess the appropriateness (i.e., validate) of the codes recorded and billed? Are claims being reviewed only to ensure they meet coding standards or are they also being reviewed to ensure medical necessity requirements were met?

6. It appears that the denial reasons cited on providers' remittance notices are somewhat misleading. For example, providers have reported the following:

   (1) "The procedure code is inconsistent with the modifier used or a required modifier is missing" when the E/M code is appended with the appropriate modifier and it has been properly utilized; and

   (2) "After clinical review, the claim does not comply with coding protocol for the modifier submitted, therefore payment cannot be made" in instances where the claim followed established coding conventions and no documentation was requested/submitted for a clinical review to actually take place.

   Is it possible for each plan's software/system to be updated to clarify that the claims have been flagged for review based on an auditing enhancement to validate that they comply with coding protocols and/or medical necessity requirements (see question #5)?

7. To date, what education has been done for providers regarding the system/software updates and the code-auditing enhancements? Were there any materials released or posted beyond what went out in BlueReview? Would HCSC consider providing formal notification to contracted providers with more robust information on the review process?

8. Would HCSC consider co-hosting an educational webinar with the AOA for impacted physicians that are contracted by BCBSIL, BCBSNM, BCBSMT, BCBSOK and BCBSTX?