Illinois Osteopathic Medical Society
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April 8, 2019

Derek Robinson
Vice President and Chief Medical Officer, Blue Cross Blue Shield of Illinois
Blue Cross Blue Shield of Illinois
300 East Randolph Street
Chicago, IL 60601

Dear Mr. Robinson,

I am writing in regards to code-auditing enhancements that were implemented in late 2017 across Blue Cross Blue Shield (BCBS) plans in Illinois. According to information released in August 2017 to providers, 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 Illinois Osteopathic Medical Society has received numerous complaints from physicians practicing in a variety of medical and surgical specialties.

A significant and growing number of physicians within BCBS's Illinois network have reported a sharp rise in automated denials of Evaluation and Management (E/M) services claims appended with modifiers 25 or 59, despite the fact that the claims in question adhere to the plans' policies and nationally accepted and sourced guidelines (e.g., Current Procedural Terminology [CPT] rules, National Correct Coding Initiative [NCCI] edits).

After reviewing these denials, we have several concerns related to the clinical validation review process. First, it appears the remark codes used on the Explanation of Benefits (EOB) are inconsistent. BCBS has used a combination of the following remark codes on the denied claims:

- CO4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
- N519: Invalid combination of HCPCS modifiers.
- CO252: Contractual obligation- an attachment/other documentation is required to adjudicate this claim/service.
- M127: Missing patient medical record for this service.
- V55: After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. For reconsideration of payment, please submit records for further review. Patient cannot be balanced billed for the disallowed amount.

These remark codes are misleading and do not provide sufficient information to physicians. They also suggest a decision about appropriate use of a modifier is made based solely on the diagnosis on the claim. This practice is not supported by the guidelines noted above.

In addition to remark code inconsistences, physicians have reported receiving conflicting information from BCBS representatives about appeal rights for claims denied during the clinical validation process. They are directed to multiple different channels to submit an appeal and oftentimes they do not receive a final notification letter of the appeal outcome.

Physicians who have followed the correct appeals process find that when a claim denial is upheld, the notification letter from BCBS does not include an adequate explanation for the denial. These letters also do not identify why the submitted documentation does not support an E/M service separate from the procedure. The language used in the letters suggests that BCBS is denying an E/M service based on the diagnosis code listed on the claim. Overall, the current design of the clinical validation process leaves physicians without any clear reasoning or opportunity for improvement.

With that said, we strongly believe there must be consistent messaging and an open line of communication between BCBS, 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 to physicians.

We hope to resolve these concerns for all Illinois physicians. In order to do so, we are requesting BCBS remove the clinical validation edit or at a minimum, provide accurate denial rationale and guidance for avoiding automatic denials.

Thank you for your consideration and your commitment to providing support to contracted physicians that are providing high-quality, patient-centered care to BCBS's members. I look forward to receiving your response by April 29, 2019.

Sincerely,

Beth A. Longenecker, DO, MS, FACOEP, FACEP
President, Illinois Osteopathic Medical Society

Cc: Opella Ernest, MD
Senior Vice President & Chief Clinical Officer
Health Care Service Corporation