

# Reconsideration Process

The reconsideration process is a process for providers to request reconsideration on the claim decisions made in the DRG Validation Review Program. The DRG Validation Review Program Reconsideration Process applies **only** to the DRG Validation Review Program.

## First Level of Reconsideration

The provider must send a written request via certified mail with any **additional** information and the rationale for the request within 45 days of certified receipt date of the DRG notification letter. The request will be reviewed by a coding professional or a registered nurse. If following this review the conclusion remains adverse, a medical doctor will review the case and make the final determination. Blue Cross Blue Shield of North Dakota (BCBSND) will respond to the provider within 45 days of the certified receipt date of the request with a determination. This level of reconsideration will determine if medical documentation and treatment provided supports the rationale for allowing the claim as originally submitted.

## Second Level of Reconsideration

The provider must send a written request via certified mail with any **additional** information within 45 days of the certified receipt date of BCBSND first level reconsideration response. An external physician consultant, with the same or similar specialty as the health care provider, will review the request. BCBSND will respond to the provider with a determination within 45 days of certified receipt date of the request. **This is the final level of reconsideration for issues related to DRG Validation with BCBSND.**

At the conclusion of the Level II reconsideration, an administrative assessment will be performed to determine if the BCBSND Reconsideration Process was conducted appropriately.

## Independent External Review

A health care provider may request an independent external review as outlined in HealthCare News 314. This external review may be requested only after exhausting all of the DRG Validation Program's reconsideration processes.

## Guidelines for Requesting a Reconsideration:

- Send a written request via certified mail.
- Send the request to:

VP Clinical Excellence and Quality  
Health Network Innovation  
Blue Cross Blue Shield of North Dakota  
4510 13th Avenue S  
Fargo, ND 58121
- The written request and the medical record information must be received within the 45-day time frame.
- Submit any additional information and the **rationale** for the request.
- Focus on the pertinent medical information.
- Submit medical documentation not previously provided.

If the attending physician and/or Medical Director wishes to discuss a claim with the BCBSND Medical Director, the appropriate time is after the first level reconsideration has taken place and the provider has received the response letter from BCBSND. After an inquiry, if a disagreement remains regarding the proposed determination, the provider may request reconsideration to the second level by submitting additional information.

## HealthCare News Articles

The following pages are copies of HealthCare News articles that pertain to the Reconsideration Process. Articles regarding the DRG Validation Program will periodically appear in future HealthCare News Bulletins.

- January 2010 – Independent External Review Process
- April 2012 – Reconsideration Process

## Independent External Review Process

A provider may request an independent external review to determine if medical care provided was medically necessary and appropriate to the claim as submitted by the healthcare provider and reviewed by BCBSND. An independent external review may be requested only after exhausting BCBSND's provider appeal process. BCBSND has contracted with North Dakota Health Care Review, Inc. (NDHCRI) to conduct independent external reviews. BCBSND will provide the medical information and medical policies used in the provider inquiry and appeal process.

The determination from NDHCRI will be the final decision and will be communicated in writing to BCBSND. BCBSND will provide written notification of the determination to the provider within 60 days from the receipt date of the completed request form.

North Dakota Century Code, Section 26.1-36-44 states, "Costs associated with the independent external review are the responsibility of the nonprevailing party." Therefore, the nonprevailing party is responsible for payment of the \$750 review fee after the final determination has been made.

To request a review, complete and submit the Request for Independent External Review form to BCBSND within 60 days following the final BCBSND appeal determination. This form can be found at [www.THORConnect.org](http://www.THORConnect.org), Provider Services, Forms.

The Independent External Review process does not apply to the following and requests will be returned to the provider:

- Benefit plan exclusions
- Self-funded employee benefit plans
- Federal Employee Program (FEP).

---

## Coding and Billing

### Outpatient and Inpatient Consults – Professional

*Effective for services on or after January 1, 2010*

To ease billing requirements for providers, and in lieu of the 2010 RVU changes, BCBSND will follow CMS's billing change related to consult codes. Effective for services on or after January 1, 2010, BCBSND will not accept CPT® codes 99241 – 99245 and 99251 – 99255. The appropriate office visit or hospital care code must be submitted. The new and established patient rules will apply in the same manner.

According to the *Federal Register*, November 25, 2009, Final Rule for the Physician Fee Schedule, CMS will



no longer allow physicians to submit claims using the American Medical Association's CPT® codes that identify Office or Other Outpatient Consultation (99241 – 99245) and/or Inpatient Consultations (99251 – 99255). These codes remain valid codes but will not be accepted by CMS. Providers have been instructed to use other appropriate E&M codes such as the new/established office visit codes and initial/subsequent hospital care codes to report these services. The Relative Value Units (RVUs) for the work component of these E&M codes, as well as the surgical global package, have been adjusted to reflect their use in replacing consults.

Modifier AI (Principle physician of record) has been created for use by the admitting physician of record for hospital inpatient and nursing facility admissions. This will distinguish the admitting physician from other physicians who provide specialty care when billing inpatient hospital care codes. When a specialty physician sees a patient for the first time as a "consult," an initial hospital care code is used regardless of when the "consult" occurs during the stay. Unless the specialty physician has admitted the patient, modifier AI should not be used in this situation. Additional visits by the specialty physician must be billed as subsequent hospital care.

#### Office or Other Outpatient Consultations (CPT® codes 99241 – 99245)

These office or outpatient consultations should be submitted using the new or established patient office or other outpatient visit codes identified by CPT® codes 99201 – 99215. The consultation codes will be non-covered as provider liable with instructions to resubmit using one of the above office visit codes.

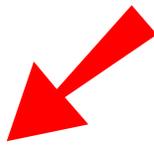
#### Inpatient Consultations (CPT® codes 99251 – 99255)

The first time a physician sees a patient in "consult," an initial hospital care code may be billed regardless of when the visit occurs during an inpatient stay. There may be multiple initial hospital care codes on the admit date or other date depending on the physician(s) who assesses the patient in "consult." However, there should never be more than one initial hospital care code per physician. Subsequent visits to the patient must be billed using subsequent care codes. Inpatient consultation codes will be non-covered as provider liable with instructions to resubmit using one of the inpatient or nursing facility day care codes.

The admitting physician must append modifier AI to the initial hospital or nursing facility care code to identify the admitting physician of record. There should only be one initial hospital or nursing facility care code with modifier AI. Any additional codes with this modifier will be non-covered as a duplicate service.

We will continue to monitor CMS guidelines for additional information related to the change in coding of consults.

## DRG Validation



### Reconsideration Process

The reconsideration process is a process for providers to request reconsideration on the claim decisions made in the DRG Validation Audit Program. This reconsideration process applies only to the DRG Validation Audit Program and is available online at [www.THORConnect.org](http://www.THORConnect.org), Provider Services, Billing & Reimbursement, DRG Validation Program.

#### First Level of Reconsideration

The provider must send a written request via certified mail with any **additional** information and the rationale for the request within 45 days of certified receipt date of the DRG notification letter. The request will be reviewed by a coding professional or a registered nurse. If following this review the conclusion remains adverse, a medical doctor will review the case and make the final determination. Blue Cross Blue Shield of North Dakota (BCBSND) will respond to the provider within 45 days of the certified receipt date of the request with a determination. This level of reconsideration will determine if medical documentation and treatment provided supports the rationale for allowing the claim as originally submitted.

#### Second Level of Reconsideration

The provider must send a written request via certified mail with any **additional** information within 45 days of the certified receipt date of BCBSND first level reconsideration response. A physician consultant, with the same or similar specialty as the health care provider, will review the request. BCBSND will respond to the provider with a determination within 45 days of certified receipt date of the request. **This is the final level of reconsideration for issues related to DRG Validation with BCBSND.** At the conclusion of the Level II reconsideration, an administrative assessment will be performed to determine if the BCBSND Reconsideration Process was conducted appropriately.

#### Independent External Review

A health care provider may request an independent external review as outlined in *HealthCare News 314*. This external review may be requested only after exhausting all of the DRG Validation Program's reconsideration processes.

#### Guidelines for Requesting a Reconsideration:

- Send a written request via certified mail.
- Send the request to:  
Director, Medical Quality  
Medical Management  
Blue Cross Blue Shield of North Dakota  
4510 13th Avenue S  
Fargo, ND 58121
- The written request and the medical record information must be received within the 45-day time frame.
- Submit any additional information and the rationale for the request.
- Focus on the pertinent medical information.
- Submit medical documentation not previously provided.

If the attending physician and/or Medical Director wishes to discuss a claim with the BCBSND Medical Director, the appropriate time is after the first level reconsideration has taken place and the provider has received the response letter from BCBSND. After an inquiry, if a disagreement remains regarding the proposed determination, the provider may request reconsideration to the second level by submitting additional information.



### Coding Counts

#### Therapeutic Phlebotomy

CPT® code 99195 (Phlebotomy, therapeutic [separate procedure]) in the Medicine section represents a therapeutic phlebotomy. This procedure is often used in the treatment of polycythemia vera to reduce the hematocrit value and red blood cell mass. Therapeutic phlebotomies are used in the treatment of other diseases as well.

Although obtaining a blood specimen is also referred to as phlebotomy, this code is not reported for the acquisition of blood specimens for laboratory services.