Level of Care Audit

General Description
The Level of Care Audit reviews all hospital claims that have a short length of stay to identify appropriate level of care.

Objective
The purpose of the Level of Care (LOC) Audit is to ensure fair and equitable utilization and billing practices are performed by all hospitals so that no hospital can improve reimbursement at the expense of other hospitals, as well as to protect the rights of our members. Blue Cross Blue Shield of North Dakota (BCBSND) is committed to ensuring that our claims database represents correct DRGs and payment amounts.

- Identify claims having variation among providers.
- Review institutional claims and corresponding medical records for appropriate level of care.
- Inform providers of audit findings.
- Educate providers regarding appropriate inpatient/outpatient surgical procedures for BCBSND.
- Educate providers regarding appropriate medical observation claims for BCBSND.

Process
1. All inpatient acute care claims submitted for payment are run through an edit process.
2. If the claim is to be reviewed, the medical record is ordered. A Registered Nurse reviews the record for severity of the illness and the intensity of the service provided to that patient to determine if the appropriate level of care was submitted for reimbursement.
3. Resources utilized for this review process include the InterQual Level of Care Guidelines, BCBSND inpatient surgical list, common medical practice within the state, and BCBSND Medical Director judgment.
4. The BCBSND Medical Director provides input for cases where inpatient criteria are not met or unusual circumstances are found.
5. BCBSND provides individual case summaries and the rationale used in making a change recommendation when disagreement with the original claim submission occurs.
6. Notification for all departments at the facility regarding a LOC adverse determination on a DRG Validation claim will be sent to the Utilization Review Department. It will be the responsibility of the Utilization Review Department at each facility to forward the information to the Business Office. Any actions that will be taken for each claim should be discussed and coordinated between the two departments.
7. The providers have 45 days following this notification to request reconsiderations. The DRG Validation Audit Program Reconsideration Process is available to all providers and consists of two levels of reconsideration.
8. Reference the Rebilling chapter regarding resubmissions.
Inpatient Status versus Outpatient Observation Status Considerations

- The provider does not need to make the determination of patient status at the time of admission.
- Providers may upgrade or downgrade a patient’s status anytime during an encounter or shortly after the stay.
- The need to change the patient status would depend on many factors including the care rendered, the intensity of the services, and the severity of the illness.
- Observation involves active treatment and care, not passive watching. A diagnosis and treatment plan may be present in observation status.
- The physical location of the service may be the same for observation and inpatient care—including ICU or CCU.
- The type of service may be similar, but the severity of illness and intensity of service are higher in the inpatient setting.
- Observation is not limited to a 24-hour period.
- Length of stay beyond one overnight does not automatically make a claim an inpatient stay.
- Observation status is appropriate when:
  - The need for an inpatient admission cannot be medically determined; or
  - Additional time is needed to evaluate the patient; or
  - The patient responds rapidly to treatment; or
  - The care needed is not intense; or
  - The patient is not acutely ill.
- Blue Cross Blue Shield of North Dakota allows the provider the opportunity to rebill a claim that should be paid at an observation level of care.
- Treatments such as IV fluids and IV antibiotics alone would not automatically qualify for inpatient status.
- It is appropriate to start as observation status when the working diagnosis is a symptom, a rule out, or a possible condition.
- Normal, expected postoperative conditions that may extend the treatment, such as pain or nausea and vomiting, would not automatically qualify for inpatient status.
- “Failed outpatient” alone may not qualify for inpatient status. Each case is reviewed on its individual circumstances and considerations.
**McKesson InterQual Criteria**

- Nationally recognized level of care criteria.
- Nurse review tool that fosters reliable, uniform, rule-based decisions and contains measurable clinical information.
- Used for screening the appropriateness of acute hospital levels of care and to screen for cases that warrant medical review.
- In 2011, InterQual began transitioning towards condition-specific subsets. If a condition-specific subset is not available for a member’s condition, the review is based on traditional subset.
- The criteria should not be used to “justify” an admission, i.e., satisfying any single criterion or group of criteria will not necessarily guarantee that an admission will be approved. Rather, the criteria represent the clinical factors that are reviewed in order to establish the necessity for acute, inpatient care.
- The BCBSND Medical Director reviews cases that do not meet the InterQual Level of Care Criteria.

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The following page is a copy of the proprietary notice that is included with information regarding how a determination was reached using the InterQual Criteria. The information you receive is proprietary and **may not** be disclosed to other parties.
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Acknowledgments: The McKesson InterQual® Criteria are developed by McKesson's clinical research staff which includes physicians, registered nurses, and other healthcare professionals. Many of McKesson's clinical staff hold advanced degrees and case management certification. The clinical content is reviewed and validated by a national panel of clinicians and medical experts, including those in community and academic practice settings, as well as within the managed care industry throughout the United States. The clinical content is a synthesis of evidence-based standards of care, current practices, and consensus from licensed specialists and/or primary care physicians.

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The Criteria reflect clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. The Criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.

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HealthCare News Articles

The following pages contain copies of pertinent information regarding the Level of Care Audit. Articles regarding the DRG Validation Program will periodically appear in future HealthCare News Bulletins.

- March 2001 – Observation Care Versus Inpatient Admission
- September 2002 – Outpatient/ASC Admissions
- September 2002 – Clarification of Determination of Patient Status
- November 2004 – Program Enhancements
- April 2006 – Glad You Asked Question and Response
- June 2008 – Outpatient to Inpatient Billing Clarification – Institutional
- December 2010 – Glad You Asked Question and Response
- July 2011 – Glad You Asked Question and Response
- December 2011 – Coding and Billing
- November 2012 – Glad You Asked Question and Response
Medical Policy

Application of Bilaminate Skin Substitutes
Effective for services on or after January 1, 2001

Update to HealthCare News #206 – revisions are in bold

Coding

15342 – Application of bilaminate skin substitute/ neodermis; 25 sq cm
15343 – each additional 25 sq cm
HCFA-1500
Q0185 – Dermal and epidermal tissue, of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter
UB-92
C1305 – Apligraf, per 44 square centimeters; or
Q0185 – Dermal and epidermal tissue, of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter

Description
These codes represent the application of tissue cultured and bioengineered skin substitute products designed to be used for treatment of skin ulcers due to venous insufficiency. One form of this technology is Apligraft™.

Policy
Benefits will be allowed for application of bilaminate skin substitute for patients with:

• Non-infected partial or full thickness venous stasis ulcers greater than three months duration which have failed to respond to documented conservative measures for at least two months.
• A limit of three separate applications of the skin substitute to any given ulcer will be allowed. There should be at least six weeks between applications.
• Reimbursement of the product itself (Q0185) will be based on invoice cost. The invoice will be required prior to the services being allowed. Reimbursement for C1305 will be based on the Hospital Outpatient Fee Schedule amount.

Observation Care versus Inpatient Admission

Many questions have been received recently regarding the proper billing of observation care versus inpatient care.

The use of outpatient observation status instead of an inpatient admission is appropriate when:

• the need for an inpatient admission cannot be medically determined; and
• additional time is needed to evaluate the patient; or
• the physician believes the patient will respond rapidly to treatment.

Outpatient observation is not limited to a 24-hour period, but in general should not exceed one overnight stay.

Observation should be used as an effective alternative until the need for admission can be clearly established or the patient can be safely discharged. The physician’s written orders should accurately reflect the setting and level of care required. In addition, the medical record documentation must support the medical necessity of the services provided.

Claims Submission

Pathologists and Radiologists Billing

Pathologists and Radiologists must submit the ordering physician’s Unique Physician Identification Number (UPIN) in form locator 17a on the HCFA-1500 claim form. This information is required to identify the ordering physician of the lab/x-ray services.
The following code combinations have been deleted:

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*Published in error in HCN #224

**DRG Validation**

**Clarification of Determination of Patient Status**

Reference *HealthCare News* #207

The following is a clarification of BCBSND's guidelines regarding inpatient versus outpatient status. These guidelines supersede any previous HCN articles that address determination of patient status. Providers may upgrade or downgrade a patient's status at any time during an encounter. The need to change the patient status would depend on many factors including the care rendered, the intensity of the services, and the severity of the illness. Unlike some other payers, this decision does not need to be made at the time of admission.

**Outpatient/ASC Admissions**

When performing procedures in the outpatient or ASC unit, and the intention is to safely discharge the patient from that facility, it is appropriate to initiate services in that setting. However, when it is planned that the patient will require an overnight stay, care should begin at the appropriate facility that has the resources to manage overnight care.

Admission for observation or inpatient care from an outpatient or ASC unit can occur, but should be the exception, and occur only when unanticipated problems and complications arise.

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*Published in error in HCN #224
DRG Validation

Program Enhancements
Effective January 1, 2005

In order to accommodate concerns raised by many hospitals about the timeliness of the DRG Validation Level of Care and Readmit/Transfer audits, these audits will be completed prior to payment. Effective for claims with admission dates on or after January 1, 2005, medical records will be requested and reviewed for those inpatient claims that fall within the current audit criteria. If, after review, it is determined that the level of care is that of an observation level, the claim will be returned to the provider to resubmit as an outpatient observation claim.

BCBSND will continue to reimburse the facility for the cost of the medical record to perform these audits. BCBSND will also continue to follow the DRG Validation Reconsideration process as noted in the DRG manual. The DRG Validation Program Reconsideration Process is documented in HealthCare News #234. We will continue to use the Interqual Criteria when performing the reviews.

The Level of Care and Readmit/Transfer audits for the 3rd and 4th quarters of 2004 will be done within the next 3-4 months. Records will be requested for the identified claims and the audits will be performed at BCBSND.

The coding audit portion of the DRG Validation program will not be changing at this time.

Policy

Participation Status in a Group Practice or Multiple Locations

A group practice shall elect participating or nonparticipating status with BCBSND for all practitioners. Should a group choose a status of participation, each eligible practitioner will sign a BCBSND participation agreement. If an individual practitioner is designated by BCBSND as nonparticipating or nonpayable under this policy, the participating or nonparticipating status of the group is not affected. “Group practice” means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association. If a practitioner, as part of a group practice, is participating with BCBSND, the practitioner shall be considered participating in all practicing locations.

Individual Practice

A practitioner shall elect participating or nonparticipating status with BCBSND. This participation or nonparticipation status shall apply to all practicing locations. Individuals choosing a status of participating will be required to sign a BCBSND participating agreement, which shall be applicable to all practicing locations.
Glad you Asked

**Question:** There are two modifiers for providers assisting at surgery (modifier 80 and AS). Is there a difference between them?

**Response:** Yes, when a provider assists a surgeon, one of two modifiers can be coded based on the particular situation:

- Modifier 80: Assistant Surgeon
- Modifier AS: Assistant at Surgery Service

Modifier 80 refers to a surgeon (a physician that performs surgery). Only the following provider types may use modifier 80:

- MD- Medical Doctor
- DO- Osteopath
- DDS- Dentist
- OD- Optometrist
- DPM- Podiatrist
- DDS/MD- Oral Surgeon

All other provider types must use modifier AS when assisting at surgery.

The procedure must be within the provider’s scope of practice and appear on the Blue Cross Blue Shield of North Dakota (BCBSND) defined Assistant at Surgery List to be reimbursed when billed with modifier 80 or AS. An assistant at surgery must be involved in the actual performance of the procedure, not simply in other ancillary services.

Claims submitted with an inappropriate modifier will be returned to the provider for correction.

**Question:** How should we bill for surgically implanted medical devices that have been recalled by the manufacturer and the replacements are provided to our facility at no cost?

**Response:** The recalled medical device should be identified by the appropriate revenue code and HCPCS (if outpatient) with a zero charge. If the hospital billing system requires a charge, the hospital should submit a token charge (e.g. $1.00) on the line for the device. The other charges in relation to the re-insertion of the device should be submitted as usual.

**Question:** Can our facility submit an inpatient claim for a patient who receives doctor’s orders to be admitted to inpatient status but either dies or is discharged prior to being assigned and/or occupying a room?

**Response:** An inpatient claim should not be submitted in this situation. Facilities should submit an outpatient type of bill (131) with the appropriate revenue and HCPCS codes.

**Examples:**

- A patient presents to the emergency room with orders for admission and either expires prior to admission or is transferred to another facility.
- A patient who presents to the emergency room and goes directly to the operating room but expires before an inpatient bed is occupied.
Outpatient to Inpatient Billing Clarification - Institutional

Reference HealthCare News #262

When a patient is a direct admit from an observation room or emergency room to an inpatient level of care, the admit date on the claim should be the date that the patient first received services in the outpatient setting. When the patient’s status changes from observation to inpatient, only room and board charges should be on the claim. Any observation charges should be converted to room and board and accounted for in revenue code 011X - 017X. The number of days of room and board must equal the number of days of the total stay. Inpatient claims (type of bill 11X) with revenue code 0762 will be returned.

Below is an example of a claim for a patient who enters the facility through the emergency room on January 1, 2008. This patient is admitted to observation status from January 1, 2008, to January 2, 2008, and then directly admitted to inpatient status from January 3, 2008, with discharge on January 5, 2008.

<table>
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<td>730</td>
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<td><strong>Total Charges</strong></td>
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<td><strong>2980.00</strong></td>
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Below is a partial UB-04 CMS-1450 claim form for the same scenario.
Glad You Asked!

Tonsillectomy and Adenoidectomy

**Question:** When a tonsillectomy and adenoidectomy are performed bilaterally, is it appropriate to append modifier 50 (bilateral procedure) to the procedure code?

**Response:** CPT® codes for tonsillectomy and adenoidectomy (42820-42836) are intended to represent bilateral procedures. Therefore, it is not appropriate to append modifier 50 when performed bilaterally. If the procedure is performed unilaterally, the appropriate code would be reported with modifier 52 (reduced services) appended.

Blood Transfusion

**Question:** If a patient receives two units of blood one day and two additional units of blood the following day, is it appropriate to report CPT® code 36430 four times?

**Response:** CPT® code 36430 (Transfusion, blood or blood components) is reported only **one** time per transfusion, regardless of how many units are administered. In this example, since the patient was transfused two units of blood one day and two units of blood the following day, it would be appropriate to report code 36430 one time for each day.

CPT® code 36430 can also be reported for any type of blood component (i.e. packed red blood cells and fresh frozen plasma) since the code description does not differentiate the blood components.

Observation Care vs. Inpatient Admission

**Question:** Does the physician’s admitting order have to correspond with the level of care billed on a patient’s claim?

**Response:** If the physician’s admitting order differs from the level of care determination, the level of care, which is based on severity of illness and intensity of service criteria, takes precedence and should be the determining factor regarding patient status when submitting a claim to Blue Cross Blue Shield of North Dakota.
**Glad You Asked!**

**2011 InterQual Criteria**

**Question:** When will Blue Cross Blue Shield of North Dakota (BCBSND) apply the 2011 InterQual criteria for DRG level of care audits?

**Response:** BCBSND is using the 2011 InterQual level of care criteria for dates of service on or after May 1, 2011. InterQual is transitioning away from body-system subsets organized by level of care and moving towards condition-specific subsets. If a condition-specific subset is not available for a member’s condition, the review is based on a traditional subset.

Adult condition-specific subsets:
- Acute Coronary Syndrome
- Asthma
- Epilepsy
- Heart failure
- Pneumonia
- Stroke/TIA

Pediatric condition-specific subsets:
- Asthma
- Croup
- Epilepsy
- Pneumonia
Providers licensed to provide ASAM II.1 should bill these services using H2035. These services must be billed on the UB-04 when provided by a facility-based Licensed Addiction Counselor. If the services are an integral part of another program, they cannot be identified separately. If an independent practitioner with the appropriate licensure provides IOP, the services are submitted on the CMS-1500 using H2035. IOP does not apply to psychiatric services.

UB-04 Admit/From Date Changes for Inpatient Claims – Institutional

Effective for “From” dates of service on or after January 1, 2012

Based on clarification from the National Uniform Billing Committee (NUBC), Blue Cross Blue Shield of North Dakota (BCBSND) can no longer require the Admit Date and From Date on acute inpatient claims to match.

For institutional inpatient claims submitted on the UB-04, the Statement Covers Period From date in Form Locator 6 (“From” Date) is distinctly different than the Admission Date in Form Locator 12 (“Admit” Date). There are times when these dates may be the same but there are also situations when these dates may be different.

The Admit Date is the date the patient is admitted as an inpatient to the facility. This date must be reported on all inpatient claims whether the claim is an initial, interim or final bill. The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included on the claim. The “From” date should be the earliest date of service on the bill.

BCBSND will implement the necessary change in its claims processing system to accommodate this clarification from the NUBC. Acute inpatient claims will continue to be reimbursed based on a DRG payment and all services on the claim will be considered to be part of the DRG payment. The patient must have continuous services in the facility prior to admission to be billed in this manner. For example, if the patient has an ER visit, leaves the facility and returns home, returns to the ER later and is directly admitted as inpatient, the first ER service is billed as a separate outpatient claim. The ER visit that results in a direct admission is billed on the same claim as the inpatient stay.

The following billing guidelines apply to all inpatient claims with a “From” date on or after January 1, 2012.

- “Admit” date (Form Locator 12) – Date the patient was admitted as inpatient to the facility. This is required on all inpatient claims regardless of initial, interim or final bill. An admit date for inpatient institutional claims must be indicated or the claim will be returned.
- “From” date (Form Locator 6) – The earliest date of service billed on the claim.
- “Through” date (Form Locator 6) – The last day of service billed on the claim. The appropriate discharge status code must be submitted in Form Locator 17.
- Room and Board (Form Locator 42 – Revenue Code 010x – 021x) – Units as submitted in Form Locator 46 must reflect the number of inpatient care days as identified between the “Admit” date and the “Through” date. The date of discharge does not count as a unit of room and board.
- ICD-9-CM Procedure Codes (Form Locator 74) – The date may be prior to the “Admit” date but must not be prior to the “From” date.
- Revenue Code 0762 – The observation room revenue code may be submitted on an inpatient claim for situations when observation is provided prior to direct admission. Units reflecting number of hours may be submitted but will not be used to calculate reimbursement as observation time is considered part of the DRG payment.
- Diagnostic tests done after the “From” date but prior to the “Admit” date can be billed on the claim. CPT®/HCPCS codes are not required as these services are considered part of the DRG payment.
- Claims will be monitored for duplicate billing of outpatient services that overlap billing dates of an inpatient claim. Any duplicate outpatient services will be non-covered as provider liable.

Chiropractic

Coordinated Treatment Plan

Purpose
Members may have condition(s) that require ongoing chiropractic services. To determine the most appropriate medical/chiropractic care and the frequency of required services, Blue Cross Blue Shield of North Dakota (BCBSND) uses a Coordinated Treatment Plan (CTP). This is not a change in chiropractic benefits and is not considered a prior approval, but rather a process to monitor and reimburse services that are effective and medically appropriate and necessary.

Definition
A CTP is a collaborative effort utilizing member’s claims history, medical history, provider(s) recommendations, and occasionally an independent consultation to determine the most appropriate medical/chiropractic care needed to support the member’s condition. The CTP is a recommendation of appropriate services and
Glad You Asked

Question:
When did Blue Cross Blue Shield of North Dakota (BCBSND) adopt the InterQual Supplemental Corrections/Revisions Criteria 2012.2 for Level of Care reviews?

Answer:
As you know, BCBSND uses InterQual Level of Care Criteria, a nationally recognized review tool when making decisions about level of care.

BCBSND received the supplemental criteria September 27, 2012, which was reviewed by the Internal Medical Policy Committee and officially adopted on October 5, 2012. BCBSND began using this supplemental criteria for dates of service October 5, 2012 and thereafter.

Additional information regarding the DRG Validation Program can be found in the manual located on THORconnect.org, Provider Services, Billing & Reimbursement, DRG Validation Program.