PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

November 2, 2020

Update: CERiS Review of High Dollar Claims

The information in this Bulletin updates Provider Bulletin P49-20.

Effective January 1, 2021, the Blue Cross Blue Shield Association (BCBSA) is changing the mandate to review high dollar institutional claims from $200,000 to $100,000.

As previously communicated, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has engaged CERiS* for itemized bill review of high dollar institutional claims. Effective September 1, 2020, CERiS started performing a review and comparative analysis of itemized billing statements against national and Blue Cross payment standards. This includes a review of charge utilization, appropriateness of charges and billing behavior to verify accurate reimbursement of claims.

Out-of-state members
Facility claims dated 9/1/20 through 12/31/20:
Facility claims that are reimbursed under a percent of charge methodology allowing $200,000 or greater will be reviewed on a pre-payment basis with the exception of Medicare Advantage groups. Medicare Advantage groups will be reviewed based on $200,000 charge rather than allowed amount.

Effective January 1, 2021, facility claims that are reimbursed under a percent of charge methodology allowing $100,000 or greater will be reviewed on a pre-payment basis with the exception of Medicare Advantage groups. Medicare Advantage groups will be reviewed based on $100,000 charge rather than allowed amount.

Blue Cross requests that the itemized bill be attached to the claim submission. If the itemized bill is not attached, CERiS will reach out to obtain the itemized bill. Upon receipt of the itemized bill from the provider, a line-item review will be conducted to determine charges that are appropriately billed. All appropriately billed charges will be processed, and in the majority of cases, charges found to be inappropriately billed will be denied as **CO 97 - M80: These charges are not covered. This service is considered part of another service.**

Minnesota members
Facility claims dated 9/1/20 through 12/31/20:
Facility claims that are reimbursed under a percent of charge methodology allowing $200,000 or greater will be reviewed on a post-payment basis.

Effective January 1, 2021, facility claims that are reimbursed under a percent of charge methodology allowing $100,000 or greater will be reviewed on a post-payment basis.

Blue Cross requests that the itemized bill be attached to the claim submission. If the itemized bill is not attached, CERiS will reach out to obtain the itemized bill. Upon receipt of the itemized bill from the provider, a line-item review will be conducted to determine charges that are appropriately billed. All appropriately billed charges will be processed, and in the majority of cases, charges found to be inappropriately billed will be denied as **CO 97 - M86:**

* CERiS is an independent company providing payment analysis services on behalf of Blue Cross and Blue Shield of Minnesota and Blue Plus.

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This service is considered to be an integral part of another service. Therefore, a separate payment cannot be made for this service.

When the requested itemized bill cannot be obtained by CERiS within 7 to 10 days, the claim will be denied as **CO 252 - N26 In order to process this claim, additional information is required.** The claim should be resubmitted with an itemized bill for each date of service reported. Electronically enabled providers should resubmit electronically.

A findings letter will be sent to the provider upon completion of the review and adjudication of the claim. The standard appeal process should be used to dispute these reviews.

Minnesota Health Care Programs

Facility claims paid under APR-DRG methodology with a calculated outlier payment of $2,500 or greater will be reviewed. The calculated reimbursement for the base APR-DRG allowed will be reimbursed to the provider with one of the following remark codes:

- **(OA 133) Cost outlier calculated outlier charges under payment review.** This remark code will be included if the itemized bill has already been received from the provider. A line-item review will be conducted for the remaining outlier charges to determine that the charges were appropriately billed.
- When the requested itemized bill cannot be obtained by CERiS within 7 to 10 days, the outlier portion of the claim will be denied as **(CO 95*)* Base DRG Pymt made. For outlier review submit itemized bill to CERiS.** A line-item review will be conducted to determine that the charges were appropriately billed once received.
- Once the line-item review of the submitted itemized bill is completed, the outlier allowed will then be processed, excluding any charges determined to be billed in error, and any additional reimbursement will be released. The remark code on the final outlier payment will be **(CO 45) – Paid per CERiS review**.

Interim claims (discharge status 30) with billed charges of $25,000 or more will be reviewed. If an itemized bill has already been received, the remark code will be **(OA 133) Cost outlier calculated outlier charges under payment review**; otherwise, the provider will receive the remark code **(CO 252) Please submit with itemized bill for CERiS review.**

General information

Providers submitting claims that qualify for review are encouraged to submit the itemized bill as an attachment to the claim to expedite processing. A findings letter will be sent to the provider upon completion of the review and adjudication of the claim. The standard appeal process should be used to dispute these reviews.