Fall 2006

CB&C NEWS

BRINGING OUR EXPERIENCES TO YOU.

Volume 3, Issue 1

CB&C, Inc. & Horizon BC/BS – again working together in the interest of Chiropractors and Physical Therapists!

Many of you know, as a result of our hard work with Empire BC/BS and Horizon BC/BS, Empire BC/BS updated their systems to allow payment of CPT 98943 for Chiropractors effective November of 2004. Chiropractors throughout NJ have been reaping the rewards since. We are very proud of this victory!

This summer, CB&C, Inc. has again been working with Horizon BC/BS on issues that will help, not just our Chiropractic & Physical Therapy providers, but every provider that submits claims to Horizon BC/BS. The following is a summary of some priority issues:

- Secondary Claim Submission & Payment—secondary payment is inconsistent and incorrect and providers receive payments for sporadic dates resulting in unnecessary phone calls and resubmissions!
- Horizon BC/BS Secondary to Medicare—this is a huge issue for Chiros!
- FEP (Federal Employee Program)—BC/BS Reps often misquote this benefit when providers call!
- CPT 98943—payment is being denied by States such as Illinois, Michigan, & South Carolina.
- Better Call Center Service—don't we all have complaints about dealing with the call centers ?

I know there are some larger fights being fought between the Chiropractic Community and Horizon BC/BS regarding their policy on physical therapy modalities - and we support those efforts! However, the issues above also greatly effect provider reimbursement, not to mention the cost of paying employees for time better spent elsewhere. Let's also mention the obvious stress and aggravation that accompanies these issues —TURN TO PAGE 3 to learn more about what CB&C, Inc. and Horizon BC/BS are working on!

Points of interest:

- *Managed Care—is your participation 'leased'?*
- *Oxford—are you being reimbursed for exams?*
- *CB&C, Inc & BC/BS—working together again!*

Oxford - are you being paid properly for 99201—99215?

Are you being paid by Oxford for your new patient exams and re-exams? Once denied, are you getting the runaround when trying to get them reprocessed? Don't write them off—read on!

We attended an Oxford/Triad seminar in 2003. During this seminar it was explained by an Oxford Medical Director that Oxford should be reimbursing exams (CPT codes 99201—99205 for new patient exams and 99211—99215 for re-exams) provided they were billed correctly. He stated that it was Oxford's policy that exams were a separate reimbursable procedure for policies NOT managed by Triad. He further clarified that if a policy was managed by Triad, exams would be covered as long as the service was authorized by the Triad reviewer. Providers expressed concerns that they were not being reimbursed for these services, but the Oxford Medical Director was confident that Oxford was working to correct this issue.

It is now more than 3 years later, and these CPT codes continue to be denied. Don't stand for it! Whether it is a policy NOT managed by Triad or a policy managed by Triad (and approval has been obtained) these CPT codes are routinely denied. In a poll conducted over the last few months, we found that most providers and their offices are writing them off instead of fighting for proper payment. We feel this is part of the problem! (continued on back cover)

Is Your Practice Suffering from 'Managed Care Contract Leasing'???

Are you a provider that limits managed care participation? Do you expect your claims to be paid at R&C (reasonable & customary) instead of insultingly low insurance carrier fee schedules? Have you been scrutinizing your EOBs for your out of network patients? You may be surprised at what you find!!

Although many providers participate with managed care contracts, just as many providers choose to remain out of network, unwilling to accept the low reimbursement rates associated with being a 'par provider'. By choosing to stay 'out of network' with carriers such as Aetna, UHC, Cigna, and Oxford, providers expect to be paid at the R&C rate of the geographic area.

Over the last two years, we started noticing that reimbursements were being reduced by these carriers (for certain policies) even for out of network providers. In some cases the EOBs clearly mentioned a network contract (other than the insurance carrier—such as Multiplan), but other EOBs had not specify a network at all.

To understand what is happening today, we must go back a few years. Many providers joined *insurance carrier networks* and *managed care networks* (there is a difference), rationalizing they would accept a lower reimbursement but would see an increase in patient volume. This may be the case with direct participation with an insurance carrier (i.e., Aetna), but looking back now, providers report it is not the case with participation in managed care networks such as Multiplan.

Unfortunately, today managed care networks (such as Multiplan) and others may be 'leasing' your contracts to insurance carriers - but not for the purpose you may have originally intended. This type of leasing does not seem to increase patient volume, and as a matter of fact, it usually does not even give you the benefit of being in-network (pt still has a deductible & coinsurance instead of a copays, etc). To make matters worse, you may not even have a contract with Multiplan as they may have leased from some other network you joined years ago! So—where is the benefit to the provider? That is the question!.

Is this happening to you? This is a example of what happened to one provider who did not even know it was happening:

Dr. Smith chose to remain out of network with the major carriers, however some years ago (when the concept of managed care was being introduced) he signed a contract with MOP Network (Phony Name). There was no evidence of increased patient volume nor has the doctor had dealings with MOP and after time forgets he even has the contract. However, in 2004 MOP network leased all their contracts to RDS Network (Phony Name) who then leased everything to DEF Network (Phony Name), who has now leased to Multiplan (NOT a phony network) who has now contracted with many of the major carriers.

Now, not only are Dr. Smith's claims being paid at the Multiplan reduced reimbursement rate, but because there is no contract with the major carrier, the deductible and coinsurance still applies as he is still considered out of network. He is not seeing increased patient volume from these leases, all he is seeing is reduced reimbursement.

Our research shows most providers don't even realize the reduction is happening!

We have seen this and similar scenarios happening to numerous providers. In this scenario, we had to help Dr. Smith track down the original contract (we went through 5 networks to do that—none of which he or we had ever even heard of) but found it stemmed from a contract he signed in 1998. To make matters worse, we sent all 5 companies letters requesting removal from all networks. We thought we were officially out of every contract and there would be no further reductions. However, then found he was back in network with Multiplan one month later because Multiplan then contracted/leased with Triad (which he participated with). At that point, as a provider contracted with Triad, he was now again subject to Multiplan reductions. Any provider contracted with Triad may want to contact them to find out if this participation ties them to networks such as Multiplan.

For providers that are having the same thing occur, find out which contracts are causing the problem. Then evaluate—what are you getting from this contract? Are you seeing increased patient volume (unless it is a one on one contact with an insurance carrier, probably not). Are the number of HMO/EPO etc. patients you are seeing (that have no out of network coverage) such a volume that they compensate for the amount you are losing per day from the patients that have well paying out of network benefits? Please contact us with any questions at (973)827-3544.







Horizon BC/BS and CB&C– continued.....

Through many meetings, we are working hard with Horizon BC/BS to implement improvements in the following areas:

Secondary Claim Submission and Payments

We have provided many many examples to Horizon BC/BS as proof that their current processing system of secondary claims is not as accurate as it should be. They are looking into how they can better improve their procedures to reduce the work of providers and Horizon BC/BS alike.

Horizon BC/BS secondary to Medicare

When consulting, we find a tremendous amount of money is lost when Medicare is primary and a carrier, such as Horizon BC/BS is secondary. First, we find that billing is often done incorrectly as offices do not explore thoroughly what type of 'secondary policy' they are dealing with (typical classifications—Supplemental Policies, Secondary Polices, or Carve-out Policies). In addition, use of the proper modifiers is imperative to obtain proper denials from Medicare. This topic in-and-of itself can be an entire article in this publication. Offices can call us at 973-827-3544 with questions about proper billing and policy identification!

After the type of policy is identified and proper billing has been done, many offices assume (and rightfully so) that if the Medicare EOB indicates the claim has been forwarded to Horizon BC/BS (for example), there is nothing else to be done. This is not necessarily the case. Medicare crossovers are usually only for the charges paid or applied to the deductible—NOT for charges correctly or incorrectly denied. When the Medicare EOB lists the 'PR__' denial for the 98943 for example, (indicating 'patient responsibility), that is payable by Horizon BC/BS. Providers assume that since the Medicare denial is accurate and since the claim was directly forwarded from Medicare to Horizon, there is nothing for the provider to do but wait to get paid—NOT SO!!! Providers currently still have to hard copy submit that claim and EOB (with denial codes) to Horizon BC/BS for proper reimbursement. How many providers get the first EOB from Horizon that pays the patient responsibility on the 98940—98942 but denies the 98943 and they accept that they will not be paid from Horizon BC/BS? - TOO MANY!!

We would like to see BC/BS pick up all information in that crossover procedure! Shouldn't it be that Horizon BC/BS promptly processed the 98940—98942 AND 98943 the first time? This is what we are working with Horizon BC/BS to accomplish!

FEP (Federal Employee Program)

Based on our persistence—Horizon BC/BS is retraining their employees in this department to quote these benefits accurately. Chiropractic offices should know they ARE entitled to be reimbursed for physical therapy modalities on these patients but ARE NOT able to be paid for CPT 98943.

CPT 98943 and States such as Illinois, Michigan, & South Carolina

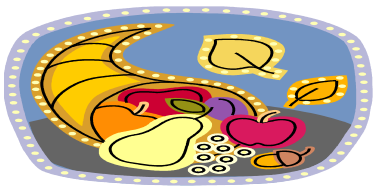
We have again identified States that are not reimbursing CPT 98943 to Chiropractors, even though the claims are being properly sent to Horizon BC/BS for pricing and then forwarded to the home plans. These States are again claiming that CPT 98943 is not covered in their State and therefore they will not reimburse NJ providers for it either. Horizon BC/BS has again teamed with us to request these States correct their processing systems for NJ providers. Each BC/BS carrier is responsible to honor the State's contract IN WHICH THE TREATING PROVIDER PRACTICES!. After all—isn't that the exact reason providers are instructed to submit the claim to the local BC/BS for re-pricing and participation status information!

Horizon BC/BS has reached out to their contacts in these States and are working on this issue. We feel it will be resolved just as Empire BC/BS inevitably corrected their processing system for NJ providers! We at CB&C, Inc. feel strongly that NJ Providers (contracted with any of the BC/BS products, including Traditional) are entitled to be paid for CPT 98943.

Better Call Center Service

We have been working with a team of Horizon BC/BS executives in hopes of improving this issue. As a team, they are tracking our phone calls, pulling tapes of our conversations, etc. to improve quality. We are emailing information from any call that does not end in a desired result-and Horizon BC/BS is listening! We are all trying to be patient in regards to an outcome!

As stated—these issues are each individually small, but together THEY ARE OMINOUS! Thanks for everyone's responses and support—keep up the good work and we will keep you posted!



CB&C Issue Quote:
Some people play the game.....others change how the game is played!!!!
...author unknown—ANJC Convention 2005

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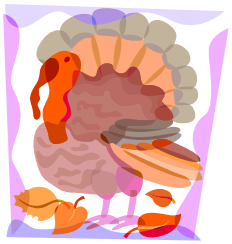

CB&C, Inc. specializes in providing services for Chiropractic and Physical Therapy Offices.

Depending on your office needs, our services include office training, consulting, insurance verifications, billing & collections and keeping offices current with the ever changing insurance industry.

Aside from working with our clients, we are also Chiropractic patients and therefore appreciate and value Chiropractic care. We understand that the less time the Chiropractor and the office staff spend on dealing with the insurance companies, etc. the more time that is available to focus on what's important—

YOUR PATIENTS!

Oxford and Exams, continued…

In the past, our procedure has been to call Oxford's customer service and request the claim be re-processed. We were told these codes denied per Oxford's processing guidelines and Reps could not override the system. We would then request a supervisor and be transferred to their 'Executive Services' department. At that level we are either told they would have the exam reprocessed (which often doesn't happen), or they would offer to do a verbal appeal on the provider's behalf, or instruct us to send in a written appeal. From that—the result was another denial!

We became tired of this game and started to send regular letters to the Oxford CEO about this issue. In this letter we would reference the meeting and outline our complaint that this issue was still not rectified. We would then attach a list of all the patients that had exam CPTs code denied. I will tell you that this CEO and his staff were very helpful and most exams were re-processed and paid. Although we appreciated the reliability of this Oxford CEO and his office staff in this regard, we continued to urge them to correct their systems so that this would not continue to be an issue in the future. Since then the project has been turned over to the office of the Senior Vice President .

As of late, we have been working directly with a Oxford representative in this office on correcting Oxford's processing system to allow these CPT codes to process when initially billed —as long as they are billed correctly and within the timeframe per CCI edits.

To all our readers—don't write those exams off! I know it involves extra work to get them paid—but there is a light at the end of the tunnel!!

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