

## How the Blue Cross Blue Shield Settlement Agreement helps the physician practice

The Blue Cross Blue Shield (“Blue Parties”) Settlement Agreement (“Settlement”) provides for greater transparency in the Blue Parties claims processing and payment practices. Through this Settlement, the Blue Parties have agreed to attempt to limit or reduce precertification requirements; provide greater notice of policy and procedure changes; and place information on their explanation of benefits (EOB) to plan members, such as the amount of payment for services provided, any adjustment to the invoice submitted, generic explanation of any adjustment to the invoice submitted and the amount, if any, for which the physician may bill the plan member (this information shall state “physician may bill you” such amount, if any, or contain substantially similar language, and will not characterize disallowed amounts, if any, as unreasonable).

Under the Settlement, certain business practices are prohibited, such as the inclusion of “gag clauses” and “all products” clauses in physician contracts. The Settlement’s protections supersede any contrary provision in the physician contract. The Settlement further requires that any new contracts be consistent with these protections, unless the physician or physician group expressly requests a modification pursuant to an Individually Negotiated Contract.

The Settlement also provides that if state law offers more protection than the Settlement, then state law applies. Physicians should be aware of relevant state laws and regulations to ensure they receive all available protections. Your state medical society will be able to assist you with this analysis.

The Settlement also provides an “Exhibit H,” which lists provisions that are specific to particular states. Please review this exhibit for special provisions for your state.

Physicians should review all contracts from every payer to understand the implications of the contract on their practices before signing. The American Medical Association (AMA) Model Managed Care Contract contains sample contract language designed to assist physicians in avoiding common contracting pitfalls. Visit [www.ama-assn.org/go/psa](http://www.ama-assn.org/go/psa) to access this material, available to AMA members at no cost.

This flier does **not** summarize or identify all of the protections provided in the Settlement. If you believe the Blue Parties are not complying with any of the settlement provisions listed below, you may initiate a compliance dispute by filing a compliance claim form. This form and detailed information regarding the settlement process is available at [www.hmsettlements.com](http://www.hmsettlements.com). Please contact your facilitator to review your

compliance options. Visit the AMA Web site at [www.ama-assn.org/go/settlements](http://www.ama-assn.org/go/settlements) for more information concerning the compliance dispute process.

The compliance dispute process is available to you at no cost and is an effective way to ensure that the Blue Parties honor their commitments under the Settlement. As an additional signatory to this Settlement, the AMA can help you. AMA members may contact the AMA Private Sector Advocacy unit for additional information.

## **Summary of “key” Blue Cross Blue Shield settlement provisions**

### **Coding rules**

- Blue Parties shall comply with most AMA Current Procedural Terminology (CPT®) codes, guidelines and conventions, unless otherwise identified on the Blue Parties physician Web site.
- Blue Parties will not automatically downcode any evaluation and management (E/M) CPT code for covered services, except to reassign a new patient to an established patient based on AMA CPT codes, guidelines and conventions.
- If a bill appropriately contains a CPT code for the performance of an E/M service appended with a CPT modifier 25 and a CPT code for performance of a non-evaluation and management service code, both codes shall be recognized and separately eligible for payment, unless the clinical documentation indicates that the use of the CPT modifier 25 was inappropriate or the Blue Plan has disclosed on its physician Web site that the code combination was not appropriately reported under their policy.
- No CPT modifier 51-exempt CPT codes are subject to the multiple procedure reduction logic or rule.
- A CPT code appended with a CPT modifier 59 will be recognized and separately eligible for payment to the extent that they designate a distinct or independent procedure performed on the same day by the same physician and that there is not a more appropriate CPT-recognized modifier to append to the code(s).
- “Add-on” codes, as designated by CPT, will be recognized and eligible for payment as separate codes and shall not be subject to the multiple procedure logic or rule.
- Supervision and interpretation CPT codes are separately identifiable and eligible for payment.
- No global period for surgical procedures will be longer than the period designated by the Centers for Medicare & Medicaid Services.
- Blue Parties shall not automatically change a code to one reflecting a reduced intensity of service when such CPT code is one among or across a series that includes, without limitation, codes that
- differentiate among simple, intermediate and complex, complete or limited, and/or size.
- Recommended vaccines and injectibles, as well as the administration of these vaccines and injectibles, will be reimbursed.
- Blue Parties will pay for newly recommended vaccines as of the effective date of a recommendation made by any of the following: the U.S. Preventive Services Task Force, the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.

## **Prompt payment requirements**

- Blue Parties shall mail a check or make an electronic funds transfer within 30 calendar days for claims. Beginning one year following the “effective date,” claims submitted electronically must be paid (by mailing a check or making an electronic funds transfer) within 15 calendar days.
- Interest will be paid at 8 percent on delayed claims.

## **Disclosure of fee schedule information, claim coding and payment policies**

- Physician fee schedules shall be made available to all contracted physicians via hard copy, CD-ROM or by electronic means not later than 12 months after the Final Order Date. The requested fee schedule will show the applicable fee schedule amounts for up to 100 CPT codes, as contained in the direct written agreement between the physician and the Blue Plan.
- Copies of contracts will be provided to physicians upon written request.
- “Payment in full” or other restrictive endorsement on a payment by Blue Parties is not binding and can be appealed.

## **Overpayment recovery**

- Blue Parties shall not initiate overpayment recovery efforts more than 18 months after the original payment.
- A 30-day written notice will be provided to the physician prior to initiating an overpayment recovery effort. The notice shall state the (i) patient’s name, (ii) service date, (iii) payment amount received by physician, and (iv) a reasonably specific explanation of the proposed adjustment.

## **Medically necessary or medical necessity definition**

- No retroactive retraction of a pre-certified medically necessary determination.
- Blue Parties shall accept the following definition of medical necessity for clinical conditions and mental health care, including treatment for psychiatric illness and substance abuse:

“Medically Necessary” or “Medical Necessity” shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

## **New physician credentialing**

New physician group members will be credentialed within 90 days of the receipt of the application. Physicians also can submit an application prior to their employment.

**Questions or concerns about practice management issues?**

AMA members and their practice staff may e-mail the AMA Practice Management Center at [practicemanagementcenter@ama-assn.org](mailto:practicemanagementcenter@ama-assn.org) for assistance.

For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call (800) 262-3211 and ask for the AMA Practice Management Center.
- Fax information to (312) 464-5541.
- Visit [www.ama-assn.org/go/pmc](http://www.ama-assn.org/go/pmc) to access the AMA Practice Management Center Web site.