of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

October 27, 2017

Michael Humphreys
Assistant Commissioner for Insurance
Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

Dear Assistant Commissioner Humphreys,

I am writing in response to the complaint the Tennessee Department of Commerce and Insurance (the "TDCI") received related to BlueCross BlueShield of Tennessee's ("BCBST's") policy for payment of anatomic pathology technical component claims. As set forth below, BCBST believes its payment methodology for anatomic pathology technical component claims is consistent with BCBST's Provider Administration Manual and institution agreements and also complies with state and federal law.

Nonetheless, due to the confusion surrounding this payment methodology as it relates to technical component services provided to patients in an ambulatory surgical center ("ASC"), BCBST will allow pathologists and independent laboratories to bill under the physician fee schedule. BCBST is making this change despite the fact that these professional services are reimbursed through the global case rates included in BCBST's contracts with ASCs. Implementation of this new policy will require changes to BCBST systems and the Provider Administration Manual. BCBST also will need to issue BlueAlert notices previewing the policy change. An estimated timeline of these changes is further outlined below.

BCBST Commercial Payment Methodology Is Consistent with Original Medicare Billing Guidelines

The billing guidelines for the anatomic pathology technical component claims for Original Medicare require that reimbursement be included in hospital inpatient and outpatient rates. These guidelines, which the Centers for Medicare & Medicaid Services ("CMS") issued in May 2013, expressly prohibit pathologists and independent laboratories that provide technical component services to Medicare beneficiaries in an inpatient or outpatient hospital setting from billing under the Medicare physician fee schedule. In addition, the same 2013 CMS guidelines permit bundling of technical component services into facility rates (*e.g.*, ASCs). When such bundling payment arrangements exist with ASCs, CMS billing guidelines do not require payment under the physician fee schedule to pathologists and independent laboratories.[1]

BCBST's contracts with facilities, such as ASCs, include payment arrangements under which reimbursement for technical component services is bundled into the facility payment. This all-inclusive payment methodology appropriately compensates the facility for the full scope of services performed. In fact, BCBST sets its all-inclusive payment rates to hospitals and other facilities, including ASCs, based on the assumption that all facility services are part of the bundle of services for which payment is being made, including technical component claims provided for facility patients regardless of where those services are

[1] The 2013 CMS guidance states in part, the following: "Payment is not made under the physician fee schedule for [technical component] services furnished in institutional settings, e.g., hospital inpatient and outpatient settings, where the [technical component' service is bundled into the facility payment. However, we are clarifying the policy to indicate that payment is made under the physician fee schedule for [technical component] services furnished in institutional settings, e.g., an [ASC], where the [technical component] service is not bundled into the facility payment." (CMS, Pub 100-04 Medicare Claims Processing, Transmittal 2714 (May 24, 2013); *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2714CP.pdf)

performed. This is reflected in BCBST's institution agreements and Provider Administration Manual.[2] Therefore, and consistent with the above CMS guidelines for payment for these services under Original Medicare, BCBST is not obligated to pay claims for technical component services under the physician fee schedule as well. If a facility arranges for the technical component of anatomic pathology services to be performed outside of the facility, the facility is electing to introduce a third-party into the provision of services, and payment to the third-party is pursuant to its arrangement with the facility. BCBST's all-inclusive payment arrangement with the facility is still appropriate for the scope of services performed, but the third-party is expected to look to the facility for payment, not BCBST.

BCBST has maintained this payment methodology under commercial contracts for several years, and recently undertook several audits to evaluate provider compliance with the billing guidelines. The audits revealed some confusion among providers as to BCBST's payment methodology. Therefore, BCBST issued a BlueAlert on July 31, 2017 reminding all providers of this payment methodology. (A copy of the BlueAlert is included for your reference.) A second BlueAlert was issued on August 31, 2017 containing this information and further clarifying that the payment methodology did not apply to Medicare Advantage claims submitted to BCBST, because BCBST payment arrangements for Medicare Advantage members do not bundle technical component services within all facility contracts and therefore BCBST allows for payment under the physician fee schedule for ASCs. The recent BlueAlerts were not a policy change. BCBST issued the BlueAlerts to clarify its commercial policy because BCBST was receiving a number of questions from providers on this topic.

BCBST Commercial Payment Methodology is Consistent with Tennessee Law

BCBST's commercial contracts and payment methodology are consistent with Tennessee law. Providers have raised four statutory bases to support their contention that BCBST's payment methodology violated Tennessee Law. BCBST disagrees with all four arguments.

First, providers claim that Tenn. Code. Ann § 56-7-1015, *Reimbursement for anatomic pathology services,* requires that providers of anatomic pathology services may only present claims for payment to certain enumerated entities, including "hospitals, public health clinics, or nonprofit health clinic ordering such services." The statute's exemptions to the direct reimbursement prohibition clearly target two main groups of providers - facilities and supervising physicians - and testimony during the enactment of the legislation supports an interpretation focused on consumer protection and preventing members from overpaying for services. Tenn. Code. Ann § 56-7-1015 was enacted before ASCs became prevalent in the State, so making a specific reference to them in statute would have required impractical foresight. BCBST believes that the timing of the statute's enactment relative to the emergence of ASCs in the industry, as well as the statute's intent to protect consumers by focusing on facilities and supervising physicians, support treating ASCs in the same manner as hospitals (and other facilities).

Second, providers claim that BCBST violated Tenn. Code. Ann. § 56-7-109(b)(3), *prompt payment standards,* by failing to "timely provide contracted providers with all necessary information to properly submit a claim." Tenn. Code. Ann. § 56-7-109(b)(3) requires that insurers provide necessary information *for providers to submit claims to the insurer*, which has been accomplished by the contract terms, Provider Administration Manual, and issuance of BlueAlerts clarifying the billing guidelines once claim filing confusion was identified through an audit. The statute does not require an insurer to inform or instruct a subcontracted provider to seek reimbursement from the referring facility that itself has contracted with BCBST to provide, and be paid for, the full scope of services.

Third, providers contend that BCBST's denial of anatomic pathology claims violated Tenn. Code. Ann. § 56-7-110, *Retroactive denial of reimbursements*. This statute requires insurers to "give the health care

---

[2] BCBST's Institution Agreements provide that the Case Rate that BCBST pays for endoscopic procedures is "all-inclusive and will fully compensate Institution for all facility Covered Services directly related to an outpatient procedure." BCBST Institution Agreement at ¶ III.A. Moreover, BCBST's provider administration manual states that "[t]he Endoscopic Gastrointestinal procedure is considered an all-inclusive service...." BCBST Commercial Provider Administration Manual at p. VI-119.

provider a written or electronic statement specifying the basis for the recoupment" and provides minimum requirements for these notifications. This statute does not apply to BCBST's payment methodology but rather to recoupments under the payment methodology. Providers' arguments also are baseless because, consistent with statutory requirements, when BCBST conducted audits on this issue, BCBST provided sufficient electronic statements and detailed audit reports specifying the basis for the recoupments.

Fourth, providers contend that BCBST's payment methodology required providers to violate Tennessee's anti-solicitation statute, Tenn. Code. Ann. § 68-29-129. BCBST's payment methodology does not require providers to solicit referrals in an improper manner. Instead, BCBST expects providers and ASCs or hospitals to negotiate in good faith on a fair market rate when the facility arranges for anatomic pathology services to be performed, in whole or in part, outside of the facility.

BCBST's Modified Payment Methodology

BCBST's payment methodology is fully supported by its contracts, Provider Administration Manual and the law. Nevertheless, as a result of confusion by providers and facilities related to BCBST's payment of anatomic pathology technical component claims and in a good faith effort to accommodate TDCI's concerns, BCBST will modify its Provider Administration Manual: BCBST will allow for reimbursement under the physician fee schedule for technical component services provided to BCBST's members that are patients of ASCs, despite the fact that reimbursement for these services is being provided to ASCs under their current contract. This change will be effective on a retroactive basis, to August 25, 2017. Anatomic pathology technical component claims with dates of service on and after August 25, 2017 can be paid under the physician fee schedule; claims with dates of service on and after August 25, 2017 that were previously adjudicated and denied based on BCBST's policy will be re-processed and payment will be made. BCBST will cease recoupment efforts related to billing/payment for anatomic pathology technical component claims for patients in an ASC for claims with dates of service prior to August 25, 2017. BCBST reserves the right to audit providers on compliance with this new payment methodology for ASC technical component claims at any time, but BCBST will not initiate recoupment efforts relating to these audits for claims with dates of service prior to January 1, 2018. Our expectation is that this time period will afford providers sufficient time to modify their billing. BCBST expects to publish a BlueAlert regarding this modified payment methodology on November 30, 2017 and will modify its Provider Administration Manual on December 31, 2017.

It is our understanding that the complainants have urged TDCI to issue a cease and desist order, as well as impose a monetary civil penalty. BCBST maintains that a violation of statute has not occurred, as outlined above, and therefore such regulatory actions are not warranted. In addition, BCBST believes our good faith effort to appease all parties by rolling back enforcement efforts for our payment policies should be considered as TDCI determines the status of this complaint and any further discussion.

If you have any questions, feel free to call me at (423) 535-3038.

Sincerely,

Marc Barclay
Vice President, Provider Networks and Contracting
BlueCross BlueShield of Tennessee, Inc.