BLUE CROSS MINUTES
November 9, 2015 RIC/RAC Meeting

BCBS REPRESENTATIVES PRESENT:
Ms. Jennifer Nelson
Ms. Kathryn Miller
Mr. Michael Lombardo

FACILITATORS PRESENT:
Ms. Jane Knight
Ms. Karen Northcutt

MS. KNIGHT: We appreciate BlueCross BlueShield being with us today. We have Jennifer Nelson, who will be leading the discussion, along with Kathryn Miller and Michael Lombardo.

I. Follow-up question from July 13, 2015 RIC/RAC meeting for Blue Advantage

1. Follow-up to Question #4.
   We have contacted KEPRO, and they do not (as of yet) adjudicate discharges for outpatients. Currently, only inpatients have discharge appeal rights through the QIO. Therefore, if an outpatient observation patient refuses to leave, should we tell the patient/patient representative to contact the plan? Should the hospital issue an ABN or other notice? Does Blue Advantage issue a letter of non-coverage?

   Response: **We do not review outpatient.**

Discussion at meeting

MS. NELSON: I apologize. In July, we should have answered it the same way. When I sent it to health management, I think they assumed I was talking about inpatient when we were talking about outpatients. So that's why they answered to refer to KEPRO. But we do not review outpatients, so there's not a process.

MS. NORTHCUTT: I think one of the questions on that would be is there any way to get a patient out of the bed that won't leave that's in an observation bed?

MS. NELSON: Well, how have you handled those in the past? And how do you handle it with Medicare patients?

AUDIENCE MEMBER: With Medicare, they have ABNs.

MS. NELSON: And that's fine to use that process. Because I would suggest using what you do for Medicare.

MS. KNIGHT: Any other questions or comments on that one?

(No response)

II. New question for Blue Advantage

2. Do we need to carve out the outpatient observation hours during actively monitored procedures?

Response: **Follow CMS guidelines.**

3. Hospitals are receiving numerous post payment DRG audits (**not** risk adjustment). We submit the medical records as requested, but we are having trouble getting the audit findings. We have been told that no results mean no findings. However, denials can get lost and appeal time is limited. It is extremely burdensome for providers to have to constantly check specific claims for recoupments for a year or more to ensure that there are no take backs. Will Blue Advantage provide a contact person or a website or a letter that will give a result of the audit findings so that these claims can be closed?

Response: **Connolly (name has changed to Cotivity) is our vendor handling these reviews. They have agreed to send out a "no findings" letter.**

Discussion at meeting

AUDIENCE MEMBER: When will that begin?

MS. NELSON: We're close to finalizing and getting the approval for the audit findings letter. We'll follow up at the next meeting and confirm it.

III. New questions for Blue Cross

4. Do we need to carve out the outpatient observation hours during actively monitored procedures?

Response: **No.**

MS. NELSON: They're asking that for commercial. And the answer to that is no.

5. Will Blue Cross consider reversing the original payment on the same remittance when they pay a corrected claim? Not reversing the payments on the same remit causes credit balances on our accounts and also causes us extra work having to go into the Blue Cross system and work the accounts on the Refund Billing Invoice Claim Auto Deduction Refunds page.

Response: **Our policy is to handle a refund and re-payment on the same remit. We have seen where this does not happen instead the refund is taken on one remit**

and the repayment happens on the next remit. We are working on a process to monitor to this activity to identify educational opportunities to our claims area.

Discussion at meeting

AUDIENCE MEMBER: So does that mean that you do agree that the payment and the reversal should be on the remit?

MS. NELSON: We do. And that's our intent for it to be on the same remit. When a person gets involved, human error takes place and that's where that problem comes in. So we're going to monitor that and we'll see what areas in claims that it's happening so we can educate those claims people.

AUDIENCE MEMBER: Thank you.

6. Is there a list available of chemotherapy drugs and/or other highly complex drugs/biologic agents that when given in their subcutaneous form should be billed using the drug administration CPT code 96372 (THER/PROPH/DIAG INJ SC/IM) and not the chemotherapy administration codes 96401-96549. For example, Cahaba posted a list of some of these drugs on their website on March 26, 2015 (http://www.cahabagba.com/news/drugs-administration-coding/).

Response: **We do not have a list separate from CMS.**

7. If a hospital based reference lab receives a specimen from a physician office does the hospital bill for the lab or can the hospital bill the physician office and the physician office bill on their visit bill?

Response: **Effective September 1, 2015, pass-through billing will no longer be permitted by Blue Cross and Blue Shield of Alabama. Pass-through billing occurs when an ordering provider requests and bills for laboratory tests, but the tests are not actually performed by the ordering provider. The performing provider should bill for these services directly. This requirement is applicable to all in network providers. Pass-through billing is permitted for Participating Hospitals *at this time*. This guideline can be found in the Provider Manual on our website (www.alabamablue.com/providers).**

Discussion at meeting

MS. NELSON: The physician cannot bill for a service they did not render. And remember this applies to laboratory tests only.

8. a) If a hospital utilizes a company in the ED that supplies splints and braces/crutches and DME supplies that dispenses in the ED can the company bill for the supply or does the hospital bill?

Response: **It should be billed by the hospital.**

b) If burn garments are dispensed in an outpatient hospital clinic are these considered DME? Should the hospital send the patient to the DME for these items or can the hospital bill for these items?

Response: **Garments used on the patient in outpatient setting, should be billed by the hospital. The patient should be given a prescription to purchase garments from a participating DME supplier for home use.**

9. Hospitals are receiving numerous post payment DRG audits (**not** risk adjustment). We submit the medical records as requested, but we are having trouble getting the audit findings. We have been told that no results mean no findings. However, denials can get lost and appeal time is limited. It is extremely burdensome for providers to have to constantly check specific claims for recoupments for a year or more to ensure that there are no take backs. Will BCBS provide a contact person or a website or a letter that will give a result of the audit findings so that these claims can be closed?

Response: **Connolly (name has changed to Cotivity) is our vendor handling these reviews. They have agreed to send out a "no findings" letter.**

Discussion at meeting

MS. NELSON: As I stated before, Connolly agreed to give a no findings letter for us. And we're working on finalizing that, getting that process in place.

10. If diagnostic tests are ordered per protocol (EKG for chest pain protocol, for example) at triage in the ED *prior to the patient being medically screened* by a physician or non-physician practitioner and the patient leaves the ED prior to being medically screened, can the hospital bill for the diagnostic test?

Response: **Yes, bill for the services rendered. We feel this would not happen often.**

Discussion at meeting

AUDIENCE MEMBER: Is that regular BlueCross or would that be Blue Advantage also?

MS. NELSON: That would be for regular BlueCross. For Blue Advantage, I'd follow

Medicare guidelines on that.

11. Please expand and report/present something on the tiered per-diems and how they are based on MS-DRG.

Response: **This topic will be handled in our presentation.**

Discussion at meeting

MS. NELSON: I'm going to turn the presentation over to Kathryn Miller. And she is going to be taking my place as the AlaHA liaison. We've had some territorial changes. And she'll talk about that and you'll kind of understand why they made a change. I've enjoyed working with you and I have enjoyed meeting different people outside of my territory that I service, so I will miss coming to Montgomery and miss handling AlaHA and learning more about facilities. But thank you for being so kind and I appreciate it. I'll turn it over to the Kathryn.

MS. MILLER: Thank you. Just a little bit of background about me. I've been with BlueCross a little over eight years. I spent my first two years in customer service, and then the remaining six years I've been in our provider network area. During that time period, I've had three different territories, so I've worked with several of you already in the past, and I look forward to working with new facilities in the future. So thank you for having me.

We have had quite a few territory changes in our network division. We had a couple of people to retire back in May, which I know several of you know, J.E. Avrard and Tina Wilhems. So they're no longer with us.

(Presentation made)

Additional discussion at meeting

AUDIENCE MEMBER: Are you just going to redo the MSDRG that we send you or how are you figuring out your MSDRG?

MS. MILLER: We take all the diagnoses codes that you have in your claim along with any procedure codes, and we run those through a 3M software to calculate our own MSDRG.

AUDIENCE MEMBER: So you're just verifying.

MS. MILLER: Yes. Yes. But we're not making our payments based on what you are putting on your claim.

MS. KNIGHT: Any other questions?

AUDIENCE MEMBER: If you make a change in the DRG, if you see a discrepancy between what we file versus what you are filing, are you noting that changed DRG or are we

supposed to just look for it?

MS. MILLER: You should validate that by looking at the remit to see if you're getting the payment that you were expecting, because the claims system does not read the DRG that you're filing. We see it, but it's not comparing and linking that together.

AUDIENCE MEMBER: But you're telling us what DRG you actually did?

MS. MILLER: We are. It's on the electronic remit now.

AUDIENCE MEMBER: So is there a way that we can have access to that grouper that you're using, that methodology, like we have access to APR DRGs? Do you have that grouper where we can know what it was?

MS. MILLER: Well, we sent out a crosswalk to say what those MSDRGs are along with the payment levels. Now, the 3M software is what we're using. A lot of facilities that I have already been working with are also using the same program. I'm not sure what program your facility is using to calculate the MSDRG.

AUDIENCE MEMBER: The new payor DRG methodology is something that 3M may want to offer us to buy, you think?

MS. MILLER: I'm not sure about that.

AUDIENCE MEMBER: Where we can calculate it ourselves?

MS. MILLER: Right.

AUDIENCE MEMBER: Okay.

MS. MILLER: But now, if you do find a discrepancy in what you were expecting, please contact your rep so we can take a look and see maybe why. Because what we have seen -- and I really see this more along the lines of the physician side than I do the hospital side. But if your software does not take up to 26 diagnosis codes or if your software doesn't allow you to send out that many and you calculated your MSDRG with those specific diagnoses codes, we're not receiving all those diagnoses codes, it's going to make a difference.

MS. KNIGHT: Other questions?

AUDIENCE MEMBER: Back on the DRG issue. From the facilities standpoint, where is your rationale going to come from if you're just putting on remit. We should be receiving a clinical rationale as to how you arrived at that calculated DRG. I understand you're saying it's coming out of software, but for us to be able to appeal something, we have to have a rationale

from you to do that, that would be a clinical rationale so that we can make the determination on the appeal, whether we agree with you or don't agree with you.

MS. MILLER: That's something we'll have to look into.

AUDIENCE MEMBER: Can we put that down as an issue?

MS. MILLER: Okay. And for all facilities that have already transitioned over, I have not had one come back and say that they calculated a different DRG. So far I have not had anybody to come back and say that.

AUDIENCE MEMBER: To follow up on her question on appeals, generally, you appeal a denial. But what's happened is you've just taken our billing and applied what you think the DRG is where there is no denial. So if you send it, we think this is what we need. How does that process work?

MS. MILLER: Well, it's not going to be a denial. It's still going to be a paid claim. It just may be at a different payment rate than what you're expecting. So then you're really going to appeal the claims payment, not necessarily the rationale.

AUDIENCE MEMBER: But you still have to have a rationale. And so do we use the regular processes that we would use for a denial?

MS. MILLER: Yes. There's an appeals form that has the different options, because there's like a bundling medical review. This should be along the lines of the payment. I would use that option.

So when we do the per diem agreement, we bundle up kind of under those MSDRGs together, groups 1 through 6. Even if we calculated a new MSDRG, likely it's going to be in that same per diem grouping. We would have to calculate something like extremely different to have a per diem group 6, what you were thinking, if we said it was a per diem group 3. So keep in mind, we're not paying based on the actual MSDRG. We're paying based on the group. And the groups are pretty broad. So I think you're going to see them when you think it should be the 6 and we paid it as a 2.

MS. KNIGHT: We thank you for coming. Kathryn, we're looking forward to working with you, and I also speak on behalf of Wesley, and we thank you Jennifer for working with us over the past few years.