BLUE CROSS MINUTES
March 13, 2017 RIC/RAC Meeting

BCBS REPRESENTATIVES PRESENT:
Ms. Kathryn Miller
Mr. David Posey

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt
Ms. Jennifer Bartlett

MR. ASHMORE: All right. We'll go ahead and start with Blue Cross. So let me welcome Kathryn Miller and David Posey.

1. Blue Advantage. Follow-up to Question #1 from November 7, 2016 RIC/RAC meeting. Please address the requirement that Blue Cross does NOT want two lines billed when billing a JW modifier for drug waste. This is opposite of the requirement for Medicare (two lines are required) and is not possible to bill with one line.

Response: **We will follow Medicare and you can submit two lines.**

Discussion at meeting

MS. MILLER: Just remember, on EAPGs, on the commercial side, it will be one line for the drug. So just make sure that for Blue Advantage, it will be two lines for drug waste.

AUDIENCE: If you bill it on one line, how are you showing your wastage? Because that's the purpose of a second line in the JW modifier, to show your wastage.

MS. MILLER: No. I'm sorry. I'm thinking of bilateral. I apologize. You're correct. I'm sorry. You're right.

2. Can Blue Cross advise if a correct OP or OBS claim can be filed after it was determined that the initial Inpatient claim that was filed was incorrect?

Response: **Yes**

Discussion at meeting

MS. MILLER: And I wasn't exactly sure when I got the question if you were talking about strictly filing a corrected claim or if you were possibly talking about a noncovered day during the middle of the stay. Yes, you can file observation if you have somebody that comes in, they do not meet InterQual for inpatient, you can file that as observation. So if you had originally filed it as inpatient and you wanted to file a corrected claim, you can file a corrected claim with observation. If you have an inpatient stay and you have a noncovered day or are in the middle of a stay, you can file ancillary services, but you cannot file observation.

AUDIENCE: So on an inpatient claim, if we don't get an outpatient with observation order, we can bill that as outpatient with observation if we know it didn't meet inpatient?

MS. MILLER: You can for commercial.

AUDIENCE: For commercial. Blue Advantage?

MS. MILLER: For Blue Advantage, I believe you have to go by what the physician's order says.

AUDIENCE: Okay. Yeah. Because I knew we could on the commercial side, but I was thinking for your Blue Advantage. You're not referring to them.

MS. MILLER: No. I'm strictly talking about commercial.

AUDIENCE: Since Medicaid has very specific guidelines for observation, does Blue Cross have very specific guidelines for observation? I know it has to be eight hours. I did find that through the EAPG information. So I find people calling all outpatients for Blue Cross observation.

AUDIENCE: What's the difference to Blue Cross outpatient and observation?

MS. MILLER: For observation, I can tell you, for EAPGs, we are not requiring a unit maximum or minimum. For EAPGs.

AUDIENCE: How about hours? I thought I read that it had to be eight. So that's not true?

MS. MILLER: No. There was an observation document that was on our website that was written by 3M, and it did have very specific number of units for observation. And if you look in the FAQs that addresses that, it says that it does not require specific number of units for observation. But there is a specific G code that you need to file for observation. I can't remember what it is off the top of my head, but it is addressed in the EAPG manual.

AUDIENCE: But are you still referring to all outpatients as observation? I mean, what's the difference in outpatient? With Medicare, we know there's a difference. There are very specific guidelines, because it's a service.

MS. MILLER: I'm not sure.

AUDIENCE: Okay.

3. Please provide documentation from Federal Blue Cross that NDC numbers are required for drug billing.

Response: **We will not be able to provide documentation in writing. Will address in the meeting.**

Discussion at meeting

MS. MILLER: Unfortunately, we are not going to be able to put anything in writing about NDCs with FEP. I do know that we do have claims where they're looking for NDC information. Washington does have a certain set of drugs that they can change the list quarterly. And they will defer in our system, and there will be some that they send to medical review. And they're looking for specific units, and they're trying to make sure that it's meeting their medical necessity. And they don't tell us which drugs those are. The ones that I have seen the most often are things like morphine, Lidocaine, Demerol, Dilaudid, things like that.

So what happens is those claims come in, they reject, they go to medical review, they review that, and then I've not really seen anything that they've not approved. I have seen where they have looked for additional records. But if they look at it, most of the time they can go ahead, approve that, and then the claim will reprocess.

What I believe they're looking for, when they're asking for the NDC, is going to be for the ones that are going to be your J codes that are the unclassified codes. So we don't really know what the drug is unless you supply the NDC information.

So, unfortunately, right now, the response we got from Washington was, no, we can't put anything in writing.

4. Please advise on billing procedure for provider when there is an inpatient acute medical claim that has a behavioral health diagnosis included in the coding (i.e., A patient overdoses on medication and ends up in an acute medical ICU bed l , which will cause a behavioral health diagnosis to be coded on the final claim. Once the patient stabilized and able for transfer to psychiatric hospital, the patient is transferred).

Response: **The 3M software determines the DRG based on ALL of the diagnosis codes filed. We used this methodology when setting up the budget neutral multiple per diems. If the overall DRG matches what was expected DRG, then the claim is correct.**

Discussion at meeting

MS. MILLER: This is a question that we've been getting quite a bit of lately. And I will tell you that there are some medical DRGs that we have on our crosswalk that does pay for the acute rate instead of behavioral health. So it will be paid based on coding, because, obviously, 3M is our software that we use to calculate the DRG.

Now, the ones that will group to the medical detox will be things like poisoning of. So if somebody comes in and overdoses, based on what I've seen on the crosswalk and I've seen the diagnosis that says something like poisoning by benzodiazepine or poisoning by whatever drug it may be. It could be a kid that accidentally got into their parent's heart medication so they OD on that, those do process with the medical acute rate. So if you have something that is withdrawal, those are not

going to be considered as medical. Those will group to one of the DRGs that has a psych rate, so you would also expect for that to process with a psych benefit.

MS. BARTLETT: When you were talking about withdrawal processing to the psych, there are some facilities in Alabama who participate with New Vision. And New Vision is a medical stabilization program for alcohol and/or drug withdrawal or impending withdrawal. It is not a behavioral benefit. It is to treat the medical portion, medical only, for the symptoms of withdrawal. Now, it will sometimes contain diagnosis that could be behavioral related, but they are actually there in an acute bed; they're not in the psychiatric unit. So we have already run into that, being new to that particular program. And there are some other facilities I think represented here who have New Vision. So if we could maybe check on that or speak to that. We're already running into them trying to send the case management piece through New Directions when, in fact, it's really a medical benefit. So the withdrawal is not strictly going to be on the behavioral side.

MS. MILLER: We can take it back, but I'll need some specific information.

MS. BARTLETT: I can get that for you.

AUDIENCE: We get tangled in the pre-authorization for generally admitted patients, where they have a medical and a psychiatric diagnosis. New Horizons doesn't want to pay if we don't get a psych auth; but the medical folks who give us the medical auth tell us it's a psychiatric admission. So could you help me understand how we get out of that issue?

MS. MILLER: So they're being admitted for medical reasons?

AUDIENCE: The patient I'm thinking about was admitted for a psychiatric diagnosis. And then the claim was initially denied because we actually had to treat him medically as well. We got a medical auth but not a psych auth. The discharge diagnosis was psych.

We probably spent 50 hours and a year and a half getting this claim paid. So I'm curious, is there any guidance you can offer for patients that are admitted for when they have medical problems and psychiatric problems, which quite a few of them do?

MS. MILLER: Yes. And we do see where members will go back and forth between medical services and psychiatric services. And we do expect an authorization for both of those because those are going to process with different benefits.

Our claims system is also now tied to JIVA, which will be the medial portion of that. So if you have both behavioral health and psych but your authorization doesn't cover all of those days, it's only going to process based on that authorization you entered through the portal through JIVA. So you'll need to separate those, and you will need to get separate authorizations.

AUDIENCE: When you say separate them, it's a one patient stay. What are you intending that we separate?

MS. MILLER: You'll need to put all of the behavioral health charges on one claim and all of your medical charges on another claim. Are they going between psych unit and a medical unit?

AUDIENCE: Possibly.

MS. MILLER: Or are these just all in one unit?

AUDIENCE: Possibly. We don't know where the patients are going to be. We're going to treat the patients in the most appropriate setting and care.

MS. MILLER: But if they are moving between psych and medical, you have two different rates that you're paid as well.

AUDIENCE: Sure.

MS. MILLER: So we do expect for those to be separated.

AUDIENCE: Got it. Okay.

MS. NORTHCUTT: Just a quick question on that. When they do move from psych to medical and they're not a psychiatric facility like you're saying, if they have dual diagnoses within a medical visit, I think where we've got both things going on and both codes are going to go to the claim, would you pay the medical piece on that one or would you deny it?

MS. MILLER: Well, you also have to remember that the primary diagnosis code that you put on the claim is going to drive whether or not it is behavioral health or medical.

So if it's a medical diagnosis, then everything that you put on there for medical will process, but it's only going to, again, allow those number of days that you've got authorized through JIVA. So even if you've got 10 days that you filed and only five of those are approved through medical, your claim is going to pay five days. So it's going to be driven by your primary diagnosis code.

MS. NORTHCUTT: I got to reading through this, just seeing that, if they came in, overdose, you treated them medically, and then, of course, at the end, after further treatment, you find that their behavioral issue was the main cause, and so at the end of the day, after treating that as well within that visit, you might have the principal diagnosis be the psych diagnosis. And if that wasn't something at all during that, that principal is going to drive that you wouldn't get paid for that.

MS. MILLER: That's right. So if they overdose, and they were in ICU, you're expecting an acute rate. Then, of course, your documentation has to support your coding, obviously. But you would want it to show that poisoning of whatever drug it was that they overdosed on. You would get the acute rate for those days. Then when they move to psych to get the treatment there, then you're going to get your psych rate for the remaining treatment.

MS. NORTHCUTT: And that would go on a different bill?

MS. MILLER: That would go on a different bill.

AUDIENCE: Two different bills?

MS. MILLER: It would be two different bills, but we would consider that as two different admissions. It's two different treatments; it's two different rates.

AUDIENCE: I'm kind of lost right there. So you're saying that if a patient is ever admitted for those diagnoses, the only thing that you are going to pay for is the primary diagnosis that we submitted. And then if it's got some psych diagnosis on it, we have to bill a whole totally new claim. It's not going to reject for that?

MS. MILLER: If you have a subpart NPI, that will allow both of those to have an admit and discharge on the same date without it duplicating. If you don't have a subpart NPI, it could duplicate having one of admit and discharge on the same day, but we could look at that and have it reprocessed for you. You know, if you do have a subpart NPI, you should be using that.

AUDIENCE: We struggle with getting authorizations from New Directions when the patient is in a medical setting. Our psych unit doesn't allow for a treatment of overdoses. So they won't take it unless the patient is admitted to an inpatient psychiatric unit. So when you're saying we need to get them authorized as a psych diagnosis but they're not taking it, we put it in JIVA, but then the code comes out as psych, and it denies.

MS. MILLER: I do know that New Directions has been reaching out to a few facilities and working with them with issues like that. So if you want to talk to me after the meeting, maybe we can get something set up or I can set up a call or something like that. But without looking at it or taking it back with me and talking to somebody about it, I really can't give you any advice today. But I'll be glad to take some examples and look through those for you.

5. When will Blue Cross have a new claims processor that will read and adjudicate all diagnosis codes submitted on an outpatient claim?

Response: **There is not anything on the horizon to change our processor.**

Discussion at meeting

MS. MILLER: Unfortunately, this is not anywhere on our horizon. I know this is a question that, as long as I've been at Blue Cross, it's going to come up, and I know it's never going to stop. I do hear that pretty much at every single offsite meeting that I have. But honestly, that's just not something that I see in our future anytime soon.

6. Can Blue Cross deny billed charges for CPT codes 77061/77062/77063 representing tomosynthesis on the remittance in order for the hospital to bill the patient? Currently these are represented as a contractual and the patient would not be responsible.

Response: ****** No, this is considered investigational and the only way to bill the member is if you have a non-covered waiver signed prior to services being rendered. The waiver has to be specific and the services rendered have to be documented along with the amount of money the member is responsible for PRIOR to services being rendered. Any investigational services will show as a write off.**

Discussion at meeting

MS. MILLER: No. We have a medical policy on this, and it's medical policy number 252. It's called digital breast tomosynthesis. And it is considered as investigational. So unless you have a noncovered waiver signed by the member, it will always go back on the remit as contractual.

AUDIENCE: Why wouldn't you put it on the remit in the noncovered section? That way, when it comes into us, the system will automatically kick it out, and if we have a waiver signed, we can bill the patient? Otherwise, it just gets covered under the contractual.

MS. MILLER: Does this one not reject back as not medically necessary? There's a difference. Because if it's a medical policy, it will typically reject as not medically necessary if it's not meeting the criteria of the policy, and that will always go to a contractual.

So, again, you could bill the member as long as you had a waiver signed. And it would have to be very specific. We've got a copy in our presentation today. But that's something that is required to bill the patient.

AUDIENCE: It doesn't come back as a CO 45? I don't know what it comes back at our hospital. I'm just asking the question, which would be in the contractual.

MR. POSEY: Right.

MS. MILLER: I'm not sure what the rejection is on your remit. But typically, if there's an actual medical policy on it, not just something that we say we don't cover, the rejection is typically not medically necessary. So I'm not sure if that comes back as a 45 or not.

7. A) If a hospital uses a patient care area in their Imaging department as an overflow for their Emergency department, providing treatment using ED Physicians and staff, is it appropriate to bill an E&M level using a 450 revenue code? The area being used is down the hall from the ED, but it is not immediately contiguous.

Response: **Yes, this would be allowed as long as treated by ED provider.**

B) If it is allowed, are there any specific criteria for signage and/or notification to the patient?

Response: **No, not if they were coming in through the ED.**

Discussion at meeting

MS. MILLER: Yes, we would allow this, as long as the member is being treated by an ED physician. You would not have to have any additional signage, because the member is coming in from through the ER, you're just using this as an overflow area, so they already realize they're coming in through the ER. So it would be a little different if they came in thinking they were coming in getting x-rays and then it gets out as ER. But as long as you're just using it as an overflow area, we do not have an issue with it as long as they're being treated by an ED physician or provider or practitioner or PA.

8. Does Blue Cross recognize locum tenens for CRNAs, NPs or PAs or just physicians?

Response: **We follow the Medicare model, physician only. We do this to be compliant for ACA and Blue Advantage.**

9. For Medicare accounts that C+ is picking up the deductible, the payment received from C+ is $500.00. The balance of the deductible is adjusted off. When this first started many years back the patient's Medicare deductible was around $768.00. Has C+ considered increasing the amount of the payment since the deductible is now $1316.00?

Response: **No, there is not a plan to increase the deductible.**

MR. ASHMORE: With no further questions, we'll let them move on to the presentation.
(PowerPoint presentation)

MR. ASHMORE: I want to thank Kathryn and David for being with us today. Thank you.