BLUE CROSS MINUTES
November 6, 2017 RIC/RAC Meeting

BCBS REPRESENTATIVES PRESENT:
Ms. Kathryn Miller
Ms. Amber Williams

FACILITATORS PRESENT:
Ms. Debbie Rubio
Ms. Karen Northcutt

MS. RUBIO: We want to welcome Kathryn Miller and Amber Williams from Blue Cross. Thank you for coming. We're going to start with the questions and answers. If you have any additional questions, if you will hold those to the end; because we want to get through these and get through the presentation, and then we'll open the floor up for questions.

I. Blue Advantage

1. Follow up to Question #1 from July 17, 2017.
Can Blue Advantage read FL70 "reason for visit" in order to appropriately adjudicate claims for Medical Necessity?

Response: **Medical policy edits are done in two different systems. Both systems are used to edit for medical policies, LCDs, NCDs and local BCBS policies.**

If the edit is in NCDE, it will read the patient reason for visit fields and all of the diagnosis code fields. If the edit is in the second system, it will only read one field, which is the PRIMARY DIAGNOSIS CODE.

Some of the local policies, LCDs and NCDS will have edits in the second system. If that is the case, it would be limited to the one field. It just depends on which system the edit is in.

Discussion at meeting

MS. MILLER: We actually have two different tables, where we house our edits for Blue Advantage and commercial. So, we do have medical policies, NCDs, LCDs. These are in both of those tables, but they're not always in the exact same table. Depending on which edit that you're specifically looking for, there is one of our tables that does read that Form Locater 70 to where it would look for the additional diagnoses; whereas, if it's sitting on one of those other tables, it's only looking at that primary diagnosis filed. So, really, it's going to be things like our medical policies that we use for commercial as well that Blue Advantage is following.
Those are going to be some of the ones that you're going to see on the one table, where it's looking at the primary diagnosis filed versus some of the edits where you got the NCDs, the LCDs, the local policies. More of those you're going to see sitting on the other table, where it's got the Form Locater 70, where it's looking at the multiple diagnosis codes. So it's not a really black and white answer, to be able to say it's always going to be read that way. It just depends on the specific edit that we're looking at.

2. Can we bill for multiple episodes of CPR performed on a patient in the emergency room? For example, if CPR is performed at 1pm and the patient is stabilized, but then requires CPR again at

1:45pm, can we bill for 2 units of 92950? Is there a certain time that should pass in between doing CPR before it is considered a separate episode? Or should we only bill for one unit no matter how many times CPR is performed while the patient is in the ED? Should additional units of 92950 be reported with modifier – 76?

Response: **CMS shows MUE 2 with MAI 3. You can file an appeal for any additional units with the medical records for the day. The 76 will not bypass the rejection and records will be required for additional unit for reimbursement. You can use the provider appeal form online.**

Discussion at meeting

MS. MILLER: For CMS, the MUE is two, but it does have a MUE adjudication indicator of three, meaning that if you submit additional records for that date of service, then we will review that. So you would be able to file more than two, but just know that a 76 modifier is not going to bypass that. You would also have to submit a record for that date of service. There is an appeal form that's on provider access that you would be able to utilize for this. So you would just look for the one that is the bundling appeal. So that's how we would handle it on the Blue Advantage side.

II. Blue Cross

3. Follow-up to Question #6 from July 17, 2017.
Please provide us with a current dated Statement of Acknowledgement with ICD-10 codes, **strictly for Outpatient Claims only**.

Response: **We are currently investigating the need to update the policy internally now that EAPGs have been implemented. There hasn't been a decision made at this time. I will have to keep on the agenda until the next meeting.**

Discussion at meeting

MS. MILLER: They felt like since the facilities had transitioned over to EAPG that they may not be necessarily needed anymore. We've got a work group that's discussing it. So as far as today, we don't have anything to where they're going to approve it, but it doesn't mean that they're not going to. They just haven't made their decision yet. So, unfortunately, I'll have to either keep it on the agenda for the upcoming meeting, or once we do get some type of announcement, we would be able to send that out through some type of provider eBlast.

4. Follow up to Additional Discussion from July 17, 2017 regarding pre-service determinations and ABNs. What is the update on the "work-in-progress" for allowing the patient to choose to go ahead with the services, but their determination was unfavorable, that they will be responsible for paying for the services?

Response: **Will address in the meeting.**

Discussion at meeting

MS. MILLER: We have found that we can assign modifiers to these, but it is not currently in production. It is something that they are working on to allow for the modifiers, and it's something that we can actually make up the modifier. You don't have to use one that's already on file. CMS will allow you to make your own modifier and then put the description with the modifiers. So that is the route that we are going with this, but it's not put into production today. They are still in the developing stages.

5. Please provide an update on EAPGs. Example: what errors are you seeing; greatest opportunity for improvement from the provider community; major changes; etc.

Response: **Will address in the presentation.**

6. Can you please provide some kind of documentation that provides guidelines on the allowed units for 90853 (Group Psychotherapy)? Providers are getting denials on the units being billed with no guidance on allowed units.

Response: **Under CMS there is an MUE of 5 and under Medicaid for EAPGs, there is an MUE of 1. Please also verify that this is the correct code. I have found a different code that allows 6 units, G0410 is group psychotherapy in a partial hospitalization setting, 45-50 minutes. Could this be a more appropriate code?**

> **G0410 - Grp psych partial hosp 45-50**
> **... g0410 grp psych partial hosp 45-50 grp... partial hosp 45-50 group psychotherapy other than of a multiple-family group in a partial hospitalization setting approximately 45 to ...**

Discussion at meeting

MS. MILLER: I tried to look at this for providers that were having an issue with it maybe prior to EAPGs and then looking at it once you've transitioned to EAPGs. What I've noticed is it seems that maybe people might be using it as a timed unit. The MUE for the 90853 for CMS is five units. If you have transitioned to EAPGs, we use Medicaid edits, not CMS. The MUE for 90853 is one. If you're using this in a partial hospitalization setting - with the providers that I've worked with this seems to be where we run into the issue of having six or more so I did some investigation and I did find another code that may be more appropriate. Now, I will give you the disclaimer, I am not a certified coder, but it does have a better description, so I thought maybe it might be something that you can look at and see if this will be more appropriate for what you're truly trying to bill. The G0410 is for group psychotherapy: In a partial hospitalization setting, other than the multifamily group in a partial hospitalization setting, approximately 45 to 50 minutes.

I'm not sure if whoever asked the question had the questions prior to EAPGs or if it was afterwards. So, whoever asked it needs to clarify, and I'll be glad to take that back.

7. Can hospitals bill CPT codes 98960, 98961, and 98962?

Example: When the education and training is provided by a respiratory therapist for patients who are not compliant with CPAP? There would be a physician's order for the education and training. This would "not" be for the education and training the patient receives when first starting CPAP.

Response: **These are non-covered codes. This would be more of a benefit issue and would have to be a specific benefit on the individual policy to be covered. Keep in mind that even though there are weights on the national weight list, doesn't mean that it will allow payment since there isn't a benefit.**

98960	428
98961	429
98962	429

Weights are showing:

428	PATIENT EDUCATION, INDIVIDUAL	23	Other ancillary tests and procedures	4	Ancillary	x	0.0512
429	PATIENT EDUCATION, GROUP	23	Other ancillary tests and procedures	4	Ancillary	x	0.1338

Discussion at meeting

MS. MILLER: I wanted you to be aware that there are going to be codes that you'll find in the national weights that it does have a weight assigned to it. But just because you find it on the list doesn't necessarily mean that there's a benefit for it, so just be aware of that.

8. Can we bill E&M for lactation consultation, especially since BCBS will accept these under EAPG? Especially since Blue Cross will accept E&M's for pregnancy and obstetrics. Example: E/M code 99201 and 99211 and a 510 revenue code.

Response: **99201 and 99211 are not the appropriate codes to bill.**

99402-99404 are for time based codes for individual counseling. Diagnosis code Z39.1 is encounter for care and examination of lactating mother.
Modifier TH is for Obstetrical treatment/services, prenatal or postpartum

Reminder that under EAPG, rev code 510 is non-covered except for FEP.

Discussion at meeting

MS. MILLER: When I looked at the code sets that we have for the preventive care services, the lactation consultation is a part of that. So I found the correct codes for that, and I listed it in my response. You'll have those exact codes, which was the 99402 through 99404, and then it gives the diagnosis code that would need to be billed with that would fall under the plans that have the healthcare perform preventative services benefits. The only thing I'm concerned about

is the 510 revenue code. I'm not sure if there is another revenue code that would be appropriate with that. The 510 is not going to have any type of payment, unless it's an FEP contract. 510 is automatically noncovered. So the only time you would get reimbursement for that 510 revenue code is going to be under an FEP policy. So even though those specific CPT codes would be allowed, the 510 revenue code is going to be the issue with that.

9. Can we bill for multiple episodes of CPR performed on a patient in the emergency room? For example, if CPR is performed at 1pm and the patient is stabilized, but then requires CPR again at 1:45pm, can we bill for 2 units of 92950? Is there a certain time that should pass in between doing CPR before it is considered a separate episode? Or should we only bill for one unit no matter how many times CPR is performed while the patient is in the ED? Should additional units of 92950 be reported with modifier – 76?

Response:

92	RESUSCITATION	5	Cardiovascular procedures	2	Significant Procedure		1.0339

Reminder that EAPG uses the Medicaid edits. This too has a MUE of 2(same as Medicare). I keyed an example and it did allow full payment on this line.

Discussion at meeting

MS. MILLER: When I looked up the MUE under Medicaid, it was the same as CMS, which was two. So anything over two would not be allowed. You will get that line kicked out on your claim if you bill more than two units. You would need to make sure that you put both units on the same line, because if you put it on individual lines, with our consolidation rules, you'll have the same EAPG, so the second line would consolidate with the first. We would allow a full payment on that, but you need to make sure you put the two units on one line. But anything over the two units would not be covered.

[presentation]

Additional discussion

AUDIENCE: Kathryn, I just need for you to confirm yes or a no. I understand that our rep, Vee, is going to go back to a different area?

MS. MILLER: Yes. That is correct. Vee Stewart, who was with me last time, has accepted a position in another area. We posted the position, and we're trying to rehire as quickly as we can. So for the time being, I will be your representative for the entire state.

AUDIENCE: So are you addressing her e-mails and things like that?

MS. MILLER: Any claims type questions, those really need to be filtered through the hospital and network mailbox. And any of those types of issues that I need to address, those will be sent

to me. Somebody that would pull that and would see that it was something they couldn't address, like the claims or anything like that, they would send that to me directly.

AUDIENCE: So she's not checking her stuff?

MS. MILLER: Yes. So don't send a direct e-mail to her. You would send any of your issues through the hospital network mailbox, and we'll get you taken care of.

AUDIENCE: But she's supposed to still be working those at this point or not?

MS. MILLER: She's already transitioned to her new role. There are a few that she was still trying to get cleaned up. So if she's still currently communicating on something with you, then she's trying to close that out. So, I mean, if it's a new issue, definitely go through that hospital network mailbox, and I will try to get that addressed for you. If it's a claims issue, then we do have an internal support group that they're going through those claims. They do work on a first in and first out basis. So it does take a little bit of time for them to get to your question and to reach out to you.

AUDIENCE: The Blue Advantage claims, the psych claims, are they billed the same as Medicare?

MS. MILLER: We did send out a Blue Advantage LOA earlier this year to where they were moving from a per diem for the day to a percent of DRG, just like we do under medical. This was for psych and rehabilitation. And the reason for that is to try to keep it more consistent, and we don't have to -- any time CMS makes an update or pricing anything with DRGs, then it keeps it consistent with that as well, instead of being that we have to continually negotiate that. Also on the UR side, it's a little bit less lenient on the health management side when it's under that percent DRG verses when it's under the per diem, they have to actually go out there and put in an authorization for each one of those members. So once it goes through the percent of DRG, all you have to do is meet the criteria to get your one day approved. Then the rest of the stay would be approved, just like it happens on the medical side, so I don't know if that answers your question.

AUDIENCE: No. That didn't help me any.

MS. MILLER: So can you re-ask your question?

AUDIENCE: The question is, say, for instance, I have Blue Advantage psych claim, okay? I bill for Medicare. My coworker's for Blue Advantage. Should she bill her claim the same as I bill my Medicare claims?

MS. MILLER: Yes.

AUDIENCE: That's what I wanted to know.

MS. MILLER: I'm sorry. I thought you were going with the pricing part of it.

AUDIENCE: Back on the group psychotherapy question and with the EAPGs, I know you said it's the Medicaid MUE.

MS. MILLER: Yes.

AUDIENCE: But prior to our EAPG date, was that still in effect, or what would be the limits?

MS. WILLIAMS: Five.

AUDIENCE: So it would be the Medicare MUE at the time?

MS. MILLER: Yes, ma'am.

AUDIENCE: On the RARC and CARC, on those two things that you said, when is it going to be implemented, you know, like a date?

MS. MILLER: They're actually already returning those. It's already being returned on the remittance, but they've not posted, like, an entire mapping, to say this is what we've mapped to each individual type of payment. So they were trying to clarify. They didn't have maybe the best CARC map to the RARCs. They were trying to clean up some of that, and then they were going to post it out there for everybody to see. So, I mean, I've given a couple here and there. I gave three today of some that you'll really see all the time, but we didn't want to put anything out there until it was the cleaned-up version.

AUDIENCE: So these three should be there on the Advantage healthcare claims, they all have Blue Cross contract numbers and group numbers, but for some reason, we're not able to submit it electronically, so most of those claims have to go through by paper. Is it something that they're going to do soon, where they could be submitted electronically?

MS. MILLER: So is this for the behavioral health? For when it transitioned from MACH to New Directions?

AUDIENCE: Yes.

MS. MILLER: Okay. Did you set up your billing with the ID for New Directions?

AUDIENCE: I'm not sure if that's been done yet.

MS. MILLER: Okay. There's a submitter ID for New Directions with the payer code, so that might be what the issue is.

AUDIENCE: Do you all have the payer ID number for New Direction?

MS. WILLIAMS: I don't have it with me, but it is on their website. If you go to the New Direction's website, it is on their website.

AUDIENCE: Okay. Thank you.

AUDIENCE: Kathryn, this is with regards to EAPGs 435 through 439, the pharmacotherapy EAPGs, we have seen, for a couple of drugs -- I think one of them is Epogen. Is that the -- as we know, EAPGs paid by line item, not necessarily by quantity given. So in this case, what we were seeing was if we have a JW modifier on this patient, so it's paying for the JW as well as for the line with the regular HCPCS J code.

MS. MILLER: Well, it's probably because we don't recognize JW.

AUDIENCE: That's maybe a silver lining, because we are getting paid something on the second line. But the question here is the quantity could change based on the weight of the patient and all that kind of stuff. And in this case; we are getting underpaid on some of the high cost drugs. So what we are noticing is that it is these EAPGs 435 and 439 that are priced low as far as weight is concerned. And the other cancer chemo drugs, they're weighted under enough where it's kind of okay. Does that make sense? So we have presented a question, do we kind of take a look at it to say can we get something that says if it is 435 through 439, these are the drugs that you might need to appeal. If they are high cost drugs, we wanted some such list that says, because we have indicated that we need to appeal, you know, on these kinds of individual basis.

MS. MILLER: I think I need to take a look at a couple of those examples.

AUDIENCE: And I can send that e-mail to you, because it has examples and everything.

MS. MILLER: Okay. I'll have to take a look at it.

AUDIENCE: Very quickly, back on the prefix that you mentioned the A1A and the A2A, is that commercial only, and are you considering Blue Advantage running out too, or did I understand that was just commercial?

MS. WILLIAMS: I have not heard it's going to be applied to Blue Advantage. At this point in time, I think it's only going to commercial.

MS. RUBIO: Okay, there are no other questions, so I want to thank Kathryn and Amber for coming today.