BLUE CROSS MINUTES
July 17, 2017 RIC/RAC Meeting

BCBS REPRESENTATIVES PRESENT:
Ms. Kathryn Miller
Ms. Vi Stewart

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Debbie Rubio

MR. ASHMORE: I want to welcome Kathryn Miller and Vi Stewart with Blue Cross today. Kathryn, I'll turn it over to you to make introductions and then we'll start the questions.

MS. MILLER: Today I brought Vi Stewart with me. She is the other provider network consultant that works with the providers in the other part of the state. She's been with Blue Cross for eight years now, and she's worked in several different departments of the company. She came from the claims area so we are super excited to have her as part of our team.

I wanted to take the opportunity today, for those of you that have not met her directly, for you to be able to at least put a face with a name. If you need one of her cards, she did bring some. At the end of the meeting, if you would just like to come up, we'll be glad to get you her contact information.

I. Blue Advantage

1. Please advise if you have written policy regarding the coding of signs and symptoms ICD-10 codes to justify Medical Necessity of an ordered test or procedure that has an associated LCD or NCD. Coders are instructed to code the final determined-most definite Dx. and this often results in a rejected facility claim as final findings Dx is not a covered Dx per the NCD or LCD.

Example: Doctor orders a breast biopsy for a lump in the breast. Dx for lump in the breast N63 is a covered code per LCD-NCD and this is coded as a reason code…Final determination is often benign and this code is not a covered code per LCD-NCD. Our procedure CPT 19081 is then denied for not meeting medical necessity. Coders are reluctant to code the reason dx other than as a reason code when final findings are documented. We have this same issue with Diagnostic colonoscopy, pt. has rectal bleeding which is covered Dx per LCD but final finding Dx internal hemorrhoids is not. These are surgical examples however we have various tests (cat scans, duplex scans, etc.) that also have a covered reason Dx but not final Dx.

Are there any plans in the future to consider reason for visit codes listed on the claim for claim processing and to support medical necessity?

Response: **There is not a written Blue Advantage policy regarding the coding of signs and symptoms. We would follow the Medicare guidelines on facility coding of signs and symptoms.**

Discussion at meeting

MS. MILLER: For Blue Advantage, we would ask that you follow the Medicare guidelines, and you file the exact same way and code the exact same way that you would to Medicare.

2. How do facilities handle discharge dispositions when a patient is discharged and presents to another acute care facility within 72 hours or less?

Response: **This will be discussed during the meeting.**

Discussion at meeting

MS. MILLER: So for this one, I'm not sure. You may need to give me some additional information. Right now, we work with CareFusion, and we do get admission, discharge, and transfer data submitted to us, if the facilities have signed a contract with CareFusion for us to be able to get that information.

So we do know when those things are happening, but as far as somebody being admitted to a different facility within 72 hours, that would count as a readmission. But we're not reaching out to a facility to say, hey, this member was already in another hospital several days prior to.

I'm not sure if that's exactly what the intention of the question was so I may need some additional guidance there from whoever it is that submitted it.

And I will tell you we are getting this information from CareFusion, and the long-term plan is for us to push this information back out to the primary care physicians to notify the providers for those members if they were in the hospital. But right now, we're in that collection gathering phase, and we're trying to get the IT to where we can push information back out.

AUDIENCE: One of our examples for the reason for that question, we have patients that we discharge and sometimes that evening or the next day, the family member decides to take them to another facility. When we go to bill, we're getting notice that they admitted to another acute care facility. That's the origin of the question. How do we handle that? We have no way of knowing until a bill is submitted. How do we address correcting the claim and resubmitting?

MS. MILLER: So why would you need to correct the claim? I would think if they discharged from your facility and then readmitted to another facility, there should be two separate bills without anything overlapping. Are you saying the days are overlapping?

AUDIENCE: What we're getting back from our business office is that the claim is not being able to be processed correctly because the discharge disposition is incorrect.

MS. MILLER: In that scenario, we would need to see the specific examples of that, because if they were overlapping, we can see that they are separate facilities, but we do need to probably work with you on those one-off scenarios. Which facility are you with?

AUDIENCE: Medical West.

MS. MILLER: I would be your provider network consultant. Go ahead and send those specific examples to me, and I'll work with you on those one-off situations.

3. Our hospital is considering the use of the Automated Breast Ultrasound (ABUS), which is to be used adjunct to mammography. The vendor suggests using CPT codes 76641 and 76642 to bill for this service. The aforementioned CPT codes represent 2D ultrasound, when the ABUS is 3D. There are no specific examples to provide at this time as we have not purchased the equipment. Prior to purchasing equipment, we would like to determine the appropriate codes to bill for this service.

Response: **We conclude that this service would need to be submitted with 76999, an unlisted code, as there is not a code currently that specifically identifies the service otherwise. CPT codes 76641 and 76642 represent 2D ultrasound, when the AWBUS is 3D, and therefore, would not be the correct codes to use. We consider this to be investigational.**

Discussion at meeting

MS. MILLER: First of all, I would like to say thank you to the facility that sent this to us in advance prior to purchasing the equipment because we don't always see that. A lot of times, we have issues on the back-end saying we didn't know. So kudos to whoever it was that sent this. We were super excited to see that you were asking it upfront, so thank you for that.

I will say that the coding that they asked you to use, we would definitely not want you to use that because that does reflect the 2D. So we would ask that you submit that as an unlisted code, and the code that they were looking for is 76999; however, it would be considered as investigational.

Our medical policy did review this, and they have used peer-published literature to show that USPSTF also reviewed it, and they could not find where there was anything. There wasn't enough data to say that anything should be done differently than it is today. So they're still saying that the standard of care today is acceptable, and there's no reason to cover this at that time.

So for now, this would be considered as investigational; however, you're always welcome to submit additional peer-published literature to be reviewed if there's something that has not already been reviewed that is currently in the medical policy. So if you need a copy of the medical policy, it should be available online, and at the end of it, you can see all of the peer-published literature that they use to review that. And those policies do typically go into a comment period, or they go into a draft format at least, depending upon how old the policy is. It may be once a year. During that time period, that's when we would ask for your physicians or others to go out and comment and submit additional peer-published literature.

AUDIENCE: Okay. So just for clarification, you're saying that any 3D has to be coded with the 76999 and not with a 76641 and a 76999 as an add-on?

MS. MILLER: No. I'm not saying that. That is specifically for this one piece of equipment.

AUDIENCE: For the ABUS?

MS. MILLER: Yes.

AUDIENCE: Okay. Thank you.

AUDIENCE: Kathryn, I just wanted to let you know we had asked the same question of Medicaid, and they have given us totally different CPTs so I'm going to give it to you to take it back and check and see. It's 76376 and 76377, this is what they're asking us to use when billing 3D breast ultrasound.

MS. MILLER: Are those codes just specific to 3D ultrasound?

AUDIENCE: We just got this. We haven't had a chance to look at it ourselves as well, but they said these are the codes that you need to use for 3D, and it says, please refer to the CPT manual for specific guidelines. I just wanted to share that so that you can look at it as well.

MS. MILLER: What I'll do is take these codes back, send them to medical policy, have those reviewed, and then I'll send the additional follow up through Peggy to send out to everybody. That or we can address it at the next meeting in November. You said that was Medicaid that gave that?

AUDIENCE: Yes.

4. If a Psych patient seen in the Emergency Room has an order to admit to Psych but is being held in the acute care Hospital for more than 1 day while waiting on a Psych bed, how should providers bill for the charges from the patient's initial presentation until the Psych bed is available?

Response: **The authorization should also include the ER if being admitted. If the treatment is for psych regardless of where they are being held, then the billing should match.**

Discussion at meeting

MS. MILLER: So our question back would be is this member being treated while they're still being held until they get a bed in a psych unit, or are they just being held until they can be transferred. If they're in the ER, or even if they're in a medical room, and they're still getting treatment for psychiatric services, regardless of where they are, we would still expect you to bill the services that are rendered. If they're still being treated for psychiatric services, then that's what we would expect to be billed. I will say if they come in through the ER that your authorization should roll back and cover through the ER as well because it would need to be through the initial hands-on care.

5. Please provide clarification on whether Blue Advantage requires NDC codes on all the drug codes submitted on a UB claim. If yes, providers need to get official notification on a workable effective date since this requires programming changes by providers that will take time.

Response: **At this time, we do not reject them, but we may not be getting the correct allowance if the NDC isn't submitted on the drug line.**

Discussion at meeting

MS. MILLER: I can tell you there is not any type of front-end edit to reject those claims, and it would not actually reject on the remit. But what you may see is that there's not an allowance on that line. We did hear that CMS was starting to require some of those NDCs. If you're not putting in an NDC, I would think you're probably just going to feel like your claim is underpaid. Until you go back and submit the NDC, you won't get the allowance that you're expecting.

II. Blue Cross

6. Follow-up to Question #5 from March 13, 2017.

Attached are copies of the Statement of Acknowledgements dated 2005 & 2009, along with the RIC minutes from Feb. 28, 2005 to give you some background. This Statement of Acknowledgement would allow medical records to list the V-code at the time as secondary and not primary. Please provide us with a current dated Statement of Acknowledgement with ICD-10 codes.

Response: **Will address during meeting**

Discussion at meeting

MS. MILLER: We have had a lot of discussions internally around this, and they have not chosen to update it yet. They are still in discussions. What we may end up doing is possibly splitting it, inpatient versus outpatient. What we run into with the inpatient side is that several years ago when we moved over to the multiple per diems and there's the crosswalk from the DRG to different levels of payments, when you start changing around the diagnosis codes, then that alters what the DRG is that you would get on that inpatient claim. So what would end up happening is if you reordered that, it will change the DRG so which payment would you expect? Would you expect the DRG from the original coding or from when you reorder the diagnosis codes?

I know there's been several people to ask this, so we may need for a few people to submit some additional information and some scenarios. Are you looking for inpatient or outpatient?

AUDIENCE: Strictly for outpatient.

MS. MILLER: For outpatient. So would anybody have an issue if we went ahead and strictly addressed it for outpatient?

AUDIENCE: Originally when we asked for this many, many years ago, it was strictly for the outpatient services. It didn't have anything to do with inpatient services, so hopefully that's helpful.

MS. MILLER: Yes. That's very helpful because I think that's really been the hesitation internally, to put that in writing, and then it really starts messing with the inpatient side of things. Since it's outpatient, I feel like that's something that we should not really have any issues with, so I will definitely get some follow up with you on that.

7. Our hospital is considering the use of the Automated Breast Ultrasound (ABUS), which is to be used adjunct to mammography. The vendor suggests using CPT codes 76641 and 76642 to bill for this service. The aforementioned CPT codes represent 2D ultrasound, when the ABUS is 3D. There are no specific examples to provide at this time as we have not purchased the equipment. Prior to purchasing equipment, we would like to determine the appropriate codes to bill for this service.

Response: **We conclude that this service would need to be submitted with 76999, an unlisted code, as there is not a code currently that specifically identifies the service otherwise. CPT codes 76641 and 76642 represent 2D ultrasound, when the AWBUS is 3D, and therefore, would not be the correct codes to use. We consider this to be investigational.**

Discussion at meeting

MS. MILLER: It's going to be the same answer as for Blue Advantage. I'll take the codes given by Medicaid and I'll address it both for commercial, FEP, and Blue Advantage for the same codes. But either way, we still consider it investigational for the commercial side as well

8. If a Psych patient seen in the Emergency Room has an order to admit to Psych but is being held in the acute care Hospital for more than 1 day while waiting on a Psych bed, how should providers bill for the charges from the patient's initial presentation until the Psych bed is available?

Response: **The authorization should also include the ER if being admitted. If the treatment is for psych regardless of where they are being held, then the billing should match.**

Discussion at meeting

MS. MILLER: It's going to be the same answer we had for Blue Advantage. If you're treating them for psych services, then that's what we would expect you to bill, otherwise, if you're not treating them, and it's basically a delay in service, then that would not be something that would be reimbursed.

AUDIENCE: Just to clarify, if they're in the ER, and they're waiting for a bed, you said the location doesn't matter. It's the treatment that matters. So the issue we have is that obviously they need to do a status change, and they transfer them to a psych bed or whatever. The effective date, from what I hear you say, for the psych claim would be two days behind. If they were waiting for psych bed for two days in the ED, it would still be T minus two, right?

MS. MILLER: Correct. It would be from the initial hands-on start of care.

9. Please provide clarification on whether Blue Cross requires NDC codes on all the drug codes submitted on a UB claim. If yes, providers need to get official notification on a workable effective date since this requires programming changes by providers that will take time.

Response: **An NDC will be required on NOC. We should not have an issue with other drugs if there is a specific code. FEP does have deferrals in their system and these are updated 4 times a year. This is based on what Washington sends. We do not have a list of drugs that will get this deferral.**

Discussion at meeting

MS. MILLER: The commercial side is going to be the same as Blue Advantage. There's not any type of edit on the front end. The difference here is where you're going to see FEP. It's going to have probably some rejections that you will see. It's going to be the NOC codes, those unclassified drugs. We will need an NDC on that, but they're not going to reject that on the front-end. So your claim will come in, but it's going to reject because they're going to need to know what is the drug being administered, what is the dosage. That's not something that we usually have an issue with getting from you when it's one of those NOC codes. It's the FEP that tends to cause an issue. So Washington updates their system four times a year, and they may hit a deferral. So when that comes in, FEP doesn't even have a list that's sent to us internally. It just comes through the system, and Washington says, here's the deferral. We need you to get additional information. So that's when you're going to see those rejections.

Has anybody seen any rejections upfront? Is there a problem that we need to look into, or was that just something that was maybe a proactive question?

AUDIENCE: I did speak to Vi about it.

This is about the EAPG 59 modifiers. Just so we have it on record, Blue Cross does not accept the X modifiers and if this applies only to commercial and/or Blue, I just wanted to make sure where – 59 modifier is the only modifier that Blue Cross recognizes. It does not read the XE, XU, XS, those kind of modifiers.

MS. MILLER: Correct

AUDIENCE: Because they hit our 3M edits so we wanted to make sure we can switch off those edits, because they don't apply to Blue Cross EAPG, correct?

MS. MILLER: Right. And you can see that. It's on provider access under FAQs too. It's number five or something, but you can find that online. It is 59 for the state procedures, so if you want that to be read and paid. That is also on the FAQs on provider access if you need somewhere to reference.

MR. ASHMORE: So that's all the questions we have unless anybody from the floor has any questions for Blue Cross or Blue Advantage.

Additional Discussion at meeting

MS. MILLER: Today we're not going to do a presentation. We were just going to talk about a few hot topics of things that we have seen recently.

One issue that has come up quite a bit recently is around the Blue Advantage pre-service determinations. Have you been getting any issues around that? Have you seen that? There was a letter

that was sent out a few months ago to the facilities. Medicare changed the rule back in 2015 to say that an ABN is not allowed for Medicare Advantage programs, so if you are currently using an ABN, as of June 1st, that is no longer allowed. We are required to do this. We fought CMS, which is why we are just now implementing it. We've been fighting them up until now, and now we have to go by their guidelines. We have to get in line. We have a pre-service determination that the physician will need to complete, and it's very similar to an ABN, but we have to notify the member in advance if something is not going to be covered. The physician has to complete a pre-service determination. They send that to us, it's either approved or denied. Then we send a letter to the member to let them know in advance if those services are going to be covered or denied.

So this is not something that we've implemented, in the past we've always said, okay, if you've got an ABN, we'll follow that as well. That's no longer the case. I think it's just been a little bit different because they've not had to do that in the past so now it causes a time delay because it's going to be about 14 days from the time that we get the information, review it, and send it out to the member. So it is going to cause some delays. We are required to do it, so it's not anything that we're going to be able to keep allowing the ABN –

Do you have a question?

AUDIENCE: What if the patient chooses to go ahead, what if they wanted to do private pay or something? Is there something we send to Blue Cross to notify them to make the patient responsible? How does that work?

MS. MILLER: It's a work-in-progress for us so that's something we're trying to work through now. If the member still chooses to do that, they definitely have the right to do that, and they could have those services, but for right now, the remit is still going to say that it's a contractual and it's a write-off. That's something that we're having to put some programming in place to be able to change that when the member wants to go ahead with those services.

For next year, we're updating the explanation of coverage to be able to be a lot more specific in that to where the member knows that this is not going to be covered because you're not going to have to do it for any of the services that are already explained by Medicare that these are not covered. So you don't have to worry about any of those services. It's just the potentially noncovered services.

AUDIENCE: What do providers need to do until that programming change happens so that if we bill it to Blue Cross, it comes back under contractual?

MS. MILLER: Not until the programming goes in, and that's something –

AUDIENCE: So we should not provide the service to the patient until Blue Cross updates the programming. Is that what you're saying?

MS. MILLER: I am not saying that.

AUDIENCE: But you are saying that we cannot bill the patient if they choose to have it anyway?

MS. MILLER: It is something that is being worked on a daily basis. It is a high priority, but I can't tell you that it's going to change tomorrow because it's not already in the system.

AUDIENCE: So there really isn't any guidance right now what we need to do for patients who want to have the service, but their determination was unfavorable with Blue Cross?

MS. MILLER: I can't give you any guidance at this time.

The next issue that we've seen a lot of recently is Cotiviti. We found out that when they're requesting records, and they've done the review and they don't find anything, we have started last year sending out a letter saying, here's a list of members we reviewed, and we didn't have any findings. We found out that they had an issue in their programming, and those letters stopped going out. They're working on that. They're getting that updated so those letters will resume, and then what they've said they will do is go back. For any of those that you did not receive, they'll go back and they'll resend those out too so you'll have something in writing. Just a heads up. They are working through that. They hope to have that resolved shortly.

The last topic I wanted to talk about is the predeterminations that are done by the physician's office that are through the online system for things like the lumbar spinal fusions. Those online predeterminations need to be attached inside your Jiva case. We have run into some issues where there's been some practices that did not want to do the predeterminations. So if you run into that, let us know because we do have the provider network consultants working with the physician practices and making sure that they understand that that is part of the CURP authorization process, and you do have to have that to be able to complete that process.

We have already been working with several of those practices. If you run into that, just feel free to shoot us an e-mail and let us know which practices those are, and we'll be glad to help out with those practices.

MR. ASHMORE: Okay. Do we have any other questions for Blue Cross? If not, I want to thank Kathryn and Vi for being here today.

MS. MILLER: Thank you.

MS. STEWART: Thank you.