BLUE CROSS MINUTES
March 19, 2018 RIC/RAC Meeting

BCBS REPRESENTATIVES PRESENT:
Ms. Kathryn Miller
Ms. Brandy Kirk

FACILITATORS PRESENT:
Ms. Karen Northcutt
Ms. Becky Miller

MS. B. MILLER: Welcome Kathryn Miller and Brandy Kirk today from Blue Cross. Thank you for coming out in today's weather. We're going to start with our Blue Advantage questions first.

I. Blue Advantage

1. Please provide guidance on the most appropriate CPT code for subcutaneous infusion of deferoxamine mesylate (Desferal) via CADD pump. For example: A patient presented to our outpatient facility for initiation of a subcutaneous infusion of J0895 - deferoxamine mesylate (Desferal) via CADD pump. The infusion was started at the facility and ordered to continue at home over 96 hours. The needle became dislodged at home so the patient discontinued the infusion after 76 hours. What CPT code(s) would be used for the initiation of the subsequent infusion via CADD? Would any subsequent visits for the same drug by CADD be reported using CPT 96521?

   Response: **We do agree that 96521 could be used.**

   Discussion at meeting

   MS. K. MILLER: We did have this reviewed by both our medical policy staff and we also sent it to our coding areas. And they all agree that the 96521 would be the most appropriate code to use. So they said that would also follow Medicare as well. So if there's any other codes that anybody has been given, we'll be glad to research those. But they did agree that the 96521 would be appropriate.

2. "New Drug Waste Guidelines" was the topic of the January 11 Blue Cross webinar. Will this also include Blue Advantage?

   Response: **Follow Medicare**

   Discussion at meeting

   MS. K. MILLER: For drug waste, we will follow CMS for Blue Advantage. On the commercial side which we have the same question on that, so I'll go ahead and address it. We did have a timely topic presentation for drug waste, although it only actually applies to the professional side. So we will now start recognizing drug waste. But as far as institutional claims, it will not be recognized. If you want to take a look at it online, it's a very short nine slide presentation. It's very straightforward. We will reimburse with the smallest vial possible. So, for example, a drug has a 100 milligram vial and a 150 milligram vial, if your facility only has the 150, we're only going to reimburse the drug waste up to the 100 because the drug is actually made in a smaller vial. So make sure that you've got the smaller vials

available on hand. If not, just know that we're only going to reimburse up to that smallest vial size that is made. It also has to be a single use and the NDC has to be present.

3. We are experiencing retrospective denials for the diagnosis of sepsis when accounts are reviewed for both coding and clinical validation. Documentation supports the diagnosis of sepsis; however reviewers are using SOFA criteria score of 2 or more. A sepsis protocol was implemented several years ago in compliance with CMS quality indicators and requires patient screening by specified criteria with implementation of specific therapeutic measures if appropriate. The physician must document the diagnosis of sepsis in the medical record before this diagnosis is coded; sepsis is not coded based upon positive screening. The rationale documented in the review results letter states "According to up-to-date criteria, in order to validate the diagnosis of sepsis, evidence of organ dysfunction caused by a dysregulated response to infection as measured by a SOFA score of 2 or greater must be demonstrated." Of course, this reduces reimbursement. The references do not actually validate Cotiviti's rationale. [an example was provided]

   Response: **We are in the process of reviewing the Sepsis concept with Cotiviti, and we are working through several specific examples with them. We are working with them Medical Director to Medical Director Level. As soon as I have additional information on the example that was submitted, I will reach out to the facility that submitted. I will have follow up on this agenda item at the next meeting.**

   Discussion at meeting

   MS. K. MILLER: We are in the process of working with Cotiviti on this. We're actually working with them at a medical director level. They're working with our associate medical director. So I did reach out to the facility that submitted this specific example, and I'll have to follow up with them specifically once they've had a chance to complete the investigation with Cotiviti directly. So there will be more to come on this one. We'll have to keep it on the agenda. But I can tell you that right now they're in the process of working together. They just were not able to actually get their call and everything taking place before the meeting.

4. We changed to the EAPG methodology January 1, 2018. As a part of this change, our claims now go through the Medicaid NCCI and MUE edits as dictated by Blue Cross. However, Blue Cross Federal claims still do now allow span dates on the claim such that all charges have the same dates of service even though performed on different dates. This causes all charges to fail NCCI and MUE edits when they really don't apply. This is causing almost all Federal claims to deny for one reason or the other. It seems as if Blue Cross Federal claims are processing under conflicting rules. What resolution can you provide us to make our claims pay on the initial submission? We have asked this question through different channels at Blue Cross and get conflicting answers as to how to process the Federal claims.

   Response: **This was an edit that was put in for Federal Employee claims that had more than 28 lines, and the claim needed to take a per day copayment. At that time our system was limited to 28 lines on a Institutional claims so the system would "roll up" revenue codes making the copayment incorrect on the claims. When BCBSAL expanded the number of lines**

beyond 28, this should have been removed. We had put in programming to remove this when EAPGs were implemented, but we found that there were still some claims getting rejections. We put in additional programming on March 13 to correct this.

Discussion at meeting

MS. K. MILLER: So you'll be happy to know we've gotten this issue corrected. What happened is prior to the EAPG implementation, which is the new outpatient methodology that I'm sure you're all familiar with by now, prior to that going in place, we had only twenty-eight lines that were allowed on the claim before the claim had to be split. And with the Federal Employee Program, they were applying co-pays to multiple days. So what was happening is they were rolling that up to one line level instead of having it on the individual levels. When EAPG's went in, they were supposed to remove that so it wasn't asking for the claim to be split or the rejections that you were seeing for that to happen. So now we can allow up to 999 lines, which I hope nobody submits a claim with 999 lines.

MS. B. MILLER: I know. I know. Those addiction recovery claims.

MS. K. MILLER: So that issue has been corrected. There were some programing issues with that. There was something that was found in the programing, and they were able to correct that. They actually put a fix in place on March 13th. So those have already gone back in and been reprocessed. And the update that I got was there were 259 claims that it impacted. It was 213 different contracts and it covered 60 facilities. So not too many from each individual facility. But you should see that corrected now.

5. Follow up to Question #4 from November 6, 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 discuss at meeting.**

Discussion at meeting

MS. K. MILLER: So at this time we still do not have anything programmed in the claims system to be able to correct the remits. The update that I was given was it would be probably around Q4 before they'll have something in place for it to actually show on the remit.

II. Blue Cross

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

Response: **Updated statement was written and attached**

Discussion at meeting

MS. K. MILLER: This one has been on the agenda for a while. So I'm happy to say we were finally able to get that one completed. And I have provided that in the packet today.

MS. NORTHCUTT: Make sure you give this to all your HIM staff and those that code the outpatient claims. It's very, very important. This is the acknowledgment that everybody laminated the first time that we got this because it actually tells you that you can make coding decisions off of these Z codes so that your claim does not fail and for the secondary prior to the Z codes because Blue Cross does not recognize all the Z codes.

MS. K. MILLER: Right. So you have a hard copy of it, but if you need it electronically, we can make sure that you get that as well. Do you have a question?

AUDIENCE: Will this apply to claims we're filing through you for other states? Are we allowed to do that on any claim that's processing through Alabama regardless of which state?

MS. K. MILLER: Yes.

7. Please provide guidance on the most appropriate CPT code for subcutaneous infusion of deferoxamine mesylate (Desferal) via CADD pump. For example: A patient presented to our outpatient facility for initiation of a subcutaneous infusion of J0895- deferoxamine mesylate (Desferal) via CADD pump. The infusion was started at the facility and ordered to continue at home over 96 hours. The needle became dislodged at home so the patient discontinued the infusion after 76 hours. What CPT code(s) would be used for the initiation of the subsequent infusion via CADD? Would any subsequent visits for the same drug by CADD be reported using CPT 96521?

   Response: **We do agree that 96521 could be used.**

8. "New Drug Waste Guidelines" was the topic of the January 11 webinar, but many were unable to dial in. Please go over the information that was presented.

   Response: **The webinar is available online and is very short and straight forward-9 slides. This does not apply to facilities. This is only for professional reimbursement.**

   Effective 01/01/2018 drug waste is allowed on the professional side. Must be clearly documented in the records, and is for single use vials only. We will only reimburse based on the smallest dose vials available. Example, drug comes in 100 mg and 150 mg vials. The hospital only has the 150 mg on hand. We will only reimburse up to the 100 mg. The NDC has to be present. Complete details are on a short webinar online.

9. When we perform quantitative drug screens where 7-14 drug classes are analyzed, we are reporting HPCPS G0481 with a quantity of one per its description. This also follows Blue Cross policy #566 on Drug Screens. However we are receiving denials for this HCPCS code and are being told by our provider rep to change the code to G0480 to get it paid. This goes against the description of the HCPCS code and the Blue Cross policy. If we are to report an incorrect code (G0480) in lieu of the correct code (G0481) we would like it in writing so we are not penalized in the future if we experience an audit or review of our documentation and claims. We have asked this question to Blue Cross and have not received an answer on this issue.

Response: **Please bill for the services that are provided. We are not asking you to change your code to meet criteria.**

Per medical policy, Limits on testing are specific for the patient, not based on the provider. A comprehensive screening panel should only be considered for initial testing when appropriate or when the patient's behavior suggests the use of drugs not commonly identified on a basic screening panel. Medical documentation must support the justification for conducting a comprehensive screening panel. Subsequent testing should only be conducted for those substances identified on the patient's initial profile.

There are different maximum amounts allowed for Pain Management (4 per 365 days) and Substance Abuse (12 per 365 days).

Page 3 of policy will give the specific criteria:
Urine drug testing in pain management or substance abuse treatment does not meet Blue Cross and Blue Shield of Alabama's medical criteria for coverage and is **non-covered** when the above criteria are not met, including but not limited to:
• routine qualitative urine drug testing (e.g., testing at every visit, without consideration for specific patient risk factors, current clinical presentation, current medication program or how the test findings will impact treatment options)
• quantitative (i.e., confirmatory) urine drug testing without qualitative (i.e., screening) urine drug testing
• the use of comprehensive **confirmatory** panels (not to be confused with a comprehensive **screening** panel)

Discussion at meeting

MS. K. MILLER: We did make sure that we've touched base with customer service and made sure that they're not telling anybody to change their codes. We certainly don't want you to change a code specifically so you can get paid. So please make sure that you're billing the accurate code for what you're providing.

Now, I think probably a little bit for this one has to do with the number of screenings that's taking place. With the urine drug policy, there are specific maximums in place. And it is not provider specific. It is not specific. So depending on how many different people those members are going to, they could have already maxed out with another provider. So your claim may be rejecting as non-covered and it's simply because they've already maxed out on the number of screenings or the

confirmatory tests that are being provided. So what this one had to do with was a confirmation panel test, and we don't allow the confirmation panel test. It's really only going to be reimbursed because of the number of units. It's the G0480 because I think that one is one up to seven. And then that next code is for eight to like fourteen or sixteen. So that's the reason for the denial, because it's a confirmation panel test. So just be careful of the number of screenings or confirmatory tests that you're rendering. If you look at the policy, it is very specific and it will tell you the exact number that will be allowed.

Now, there is a difference in a member that's being treated for chronic pain versus substance abuse. So there are different maximums in place. They're certainly not going to have the same thing. If you look in the policy, it also will exclude things like ER. That doesn't apply in that setting. So just make sure you're taking a look at the medical policy and it will give you the specific maximums.

10. Are denied inpatient claims eligible to be billed as OBS? What does that require? A new order? How long after admission/appeal/denial is allowable?

Response: **If a claim is rejected for no authorization, the hospital needs to review the admission and follow the CURP process. If the denial was sent to be reviewed, and non-covered by Peer Advisor Reviewer, then you can file a corrected claim as observation.**

Please keep the following scenarios in mind when doing this and this is general information.

Scenario 1: A member that is admitted for general medical (no surgical procedures) and does not meet Interqual critera, observation would be appropriate to bill.

Scenario 2: If the member has a denied day during the middle of the stay for something like a delay in service, then the non-covered day will be allowed to bill for ancillary services only on a 12X (outpatient) type of bill.

Scenario 3: If the member is admitted for a surgical procedure (possibly non-covered) and the procedure doesn't meet medical policy criteria, then the entire stay is denied and not allowed to bill as outpatient.

Blue Cross and Blue Shield of Alabama does not require an inpatient admission order by the physician. Blue Advantage will follow CMS and will require documentation.

Mandatory Medicare Outpatient Observation Notice

All hospitals and critical access hospitals (CAHs) are required to provide the Medicare Outpatient Observation Notice (MOON), form CMS-10611, per CMS guidance, to all Medicare beneficiaries, including Medicare Advantage enrollees. This notice informs Medicare beneficiaries (including health plan enrollees) that they are outpatients

receiving observation services and are not inpatients of a hospital or CAH. You should provide the form to patients receiving observation for more than 24 hours.

The MOON form is mandatory under the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act). See the **"Beneficiary Notices Initiative (BNI)" web page**

Discussion at meeting

MS. K. MILLER: Well, really it all depends on the scenario. Yes, you can bill for observation if somebody is not meeting in-patient criteria. We do not require the physician order to determine that. We would like to see that in the medical record, but we're not going to deny a claim because there's not a physician order. Now, Blue Advantage will be different. We are going to obviously follow Medicare when it comes to the observation for that. Now, I did write in here a few different scenarios that we can talk about.

The first one, if a member was admitted for general medical, no surgical procedures whatsoever and they're not meeting InterQual criteria, observation would be appropriate to bill. So for that it's very easy. You can just submit a corrected claim if you had originally gotten your in-patient claim denied for no authorization.

Now, of course, I'm assuming you're asking this question about the claim. You've already gone through the appeals of while the member was in-patient, trying to get that overturned. So if you've gotten past that point, your in-patient claim denied, you can bill that as observation for outpatient. Any questions on that scenario? That was pretty straight forward.

Number two, if a member has something like a delay in service in the middle of their stay, you can bill your in-patient claim saying which days are covered and which days are non-covered. Then you can bill your ancillary services on an outpatient claim which would be a 12X type of claim. So we're not saying that maybe those labs or tests that were done that day didn't need to be done. But, however, if there's a delay in service, it's not going to be covered at the in-patient rate. So you can bill those ancillary services only when you have a delay in service or you have a non-covered day in the middle of a stay. Any questions on that scenario?

Okay. Last one. If somebody is having a procedure that's on the possibly non-covered list, now, we all know those are going to have medical policy to go along with them. So if somebody has a procedure possibly non-covered and it does not meet criteria, then you would not be able to bill observation. The entire stay is going to be denied because if it's not meeting criteria for the procedure, nothing is going to be reimbursed. Any questions?

MS. B. MILLER: I guess everybody is okay with that.

AUDIENCE: Not really.

MS. K. MILLER: Well, now, I do want to also mention for Blue Advantage, make sure that the MOON form is being utilized for any of your Medicare or Medicare Advantage patients to make sure that they're aware even if they're there for multiple days, if it's outpatient, they need to be aware that it is outpatient services.

AUDIENCE: Just to be clear on scenario number three. If we notify the patient up front that this is potentially non-covered services, patients are being told that we're not allowed to bill them. We're giving them notification straight up front –

MS. K. MILLER: You're correct.

AUDIENCE: -- that yes, they will be.

MS. K. MILLER: Yes, you can do that for commercial members. You can't do that for Blue Advantage. But for commercial, absolutely. If you have a non-covered waiver signed up front prior to services being rendered, it's very specific with the procedure that's being performed and the amount of money that they're going to owe, then, yes, you can bill the member. We do have a non-covered waiver on our website. You're not required to use it, but you are welcome to use it. You can develop your own. It just has to be very specific.

AUDIENCE: When customer service calls us and tells us we can't bill the patient and we say we have a signed notice up front, what are they supposed to do to flag it and get back in touch with the patient and ask them did you sign this, because if you did, you can be billed.

MS. K. MILLER: Yes. And they should be following up with the member to let them know that that is allowed as long as they do have something in writing. Now, I will say there are times where the member may still argue that fact and there have been times where legal gets involved and I have to call and ask somebody for a specific waiver. So if that happens, just please, please make sure it is very clear how much the member owes and the procedure that was performed. Because if it comes back and it says you're responsible for anything that Blue Cross doesn't cover, that does not cover it. And those situations, you will have to write those off. But if that happens and somebody has not notified the member, please let us know and we are happy to contact customer service and have that member contacted. That is not a problem.

AUDIENCE: Just as a suggestion, when that occurs, maybe what customer service ought to respond to instead of saying, Oh, the provider can't bill you and gets on the phone with us, is, Did you sign a waiver, Mr. Patient?

MS. K. MILLER: I'll say that a lot of times -- because before I've been in this role, I came through customer service. And I will tell you a lot of times what you say and what they interpret are two totally different things. And it is also at the end of the day, they don't want to be responsible for the amount of money. So, I hate to say it, but, I mean, sometimes you have to kind of take it with a grain of salt. And when they say or when they start asking those questions, the member may or may not remember that or it may not say that. So when that happens, that's when it gets escalated up to our area and then we have to start calling and asking for copies of these things and then we have to put it on file with the contract. So, we can always get those scenarios worked out. We can all touch base with the member and let them know that, no, you are responsible for this. I do have a copy of it. We just need to know when this happens, and we're happy to take care of it.

AUDIENCE: It usually does get taken care of. It's just a very arduous process and we have to call back and forth, back and forth until it gets resolved.

MS. K. MILLER: I understand.

Additional discussion at meeting

MS. K. MILLER: We have a few hot topics that we'll talk about today. Brandy Kirk is my new partner. So she is now going to be working with the southern part of the state. Brandy is actually an RN. She's been with Blue Cross for close to seven years. So she was actually our Baby Yourself nurse for any of you that are familiar with that program. She was one of our case managers. So Brandy is going to talk about our hot topics today.

MS. KIRK: And I'll try to go through these pretty quickly because I know everybody is a little worried about the weather. Just to update, I've had a few questions regarding mental health claims and how to file those. As you know, Blue Cross partnered with New Directions several years ago and MHCA has rolled off as of 10/1/17. So for filing your mental health claims -- and I'm going to read this to make sure that I get this correct. For dates of service prior to 10/1/17, if the patient had EPS benefits and the provider was EPS, you must file to New Directions. If the provider was not EPS or the patient had Blue Choice or any other benefit structure, you can file the claims to Blue Cross. We are processing the claims in timely filing limits of the contract. For dates of service 10/1/17 and forward, if the provider has EPS and the patient has EPS, you should send the claims to New Directions. If the provider is not EPS or even if the provider is EPS but the patient is not EPS, the claims will come to Blue Cross.

Would you like for me to repeat it? Was that yes or no?

AUDIENCE: Yes.

MS. KIRK: Okay. All right. For dates of service prior to 10/1/17, if the patient has EPS benefits and the provider was EPS, you must file to New Directions. If the provider was not EPS or the patient had Blue Choice or any other benefit structure, you can file the claims to Blue Cross/Blue Shield of Alabama. For dates of service 10/1/17 and forward, if the provider has EPS and the patient has EPS, you should send the claims to New Directions. If the provider is not EPS or even if the provider is EPS but the patient is not EPS, the claims come to Blue Cross. And, of course, you can contact Kathryn or me since I have a feeling that may have been a little unclear.

MS. K. MILLER: So basically MHCA is no longer processing claims. So anything that you would have filed to MHCA prior to New Directions coming in, you're going to file that to us now so that we can process those in the place of MHCA. Does that help clarify anything? I mean, basically anything MHCA send to us.

MS. KIRK: The next thing, your hospitals may have received a letter regarding this. As Blue Cross transitioned to multiple per diems, they partnered with Sante Analytics for a coding review and errors were found. So as a result of the errors being found, there are going to be more hospital coding audits, and your facility will receive a letter, if they have not already, to be notified of this.

AUDIENCE: What's the name? I'm sorry.

MS. KIRK: Sante. It's SANTE Analytics.

MS. K. MILLER: So they did a pilot last year sometime. And basically we're going to be doing DRG audits on the commercial side. And there were letters that went out, I want to say sometime in Q4 last year, to let you know about this. So in the pilot phase, if there was a finding, they didn't take anything back. They were really just kind of looking to see what was going on. What did the claims look like compared to the records? So since they did see a considerable amount, they decided to go ahead and move forward and do just kind of like what we do on the Blue Advantage side. And so now there will be DRG audits on the commercial side.

AUDIENCE: I'm sorry. Just so we're clear, the letterhead, the letter will be from Sante, whatever that company?

MS. K. MILLER: It will. The same as like Cotiviti comes out, it's one of our partners. So it will have Blue Cross in the letter, but it will be coming from Sante.

AUDIENCE: And, also, I guess who does it go to? Would it be the same as we got from Cotiviti?

MS. K. MILLER: It will be like Cotiviti. It will give you all of the information in there. I don't even think anything has really started yet as far as anything new. This was a pilot they did for a short time. So I don't know if they're currently doing any audits right now. But there was a letter to let you know that at some time, I want to say mid-2018, that's when they're going to start. So you'll start receiving additional letters to let you know that it's coming.

AUDIENCE: Okay. We just want to know who to ask did you get a letter.

MS. KIRK: And as you know, Cahaba GBA transitioned to Palmetto GBA on 2/26/18. So as of 2/26/18, all Blue Advantage programs are going to follow the local and national policies of Palmetto. So just remember that. As for EAPG, we are currently working on a webinar to answer questions and address issues that everybody or some people may be having. So expect an E-mail to come out within the next week or two just asking you to submit any specific questions or issues that you're having so that way we can work to address those in the webinar. And then we'll update you as to when the webinar is coming out.

AUDIENCE: I might have missed it. So you're the provider rep for this area?

MS. K. MILLER: For which area?

AUDIENCE: For the South, for Alabama.

MS. KIRK: We are going in systems. So I have Mobile and the very, very Deep South. Kathryn has Montgomery. I go back up and have Calhoun County, Etowah.

AUDIENCE: Specifically, Elmore County.

MS. K. MILLER: I think I have Elmore County now. Sorry. We just have a new map and it is posted online. I've never come down that far. But like she said, we're trying to keep systems together instead of breaking those up because a lot of times when we do reporting and things like that, you've got two different reps for one hospital system. It just doesn't make sense. So we tried to clean some of that up. So now I will be actually working with Elmore.

AUDIENCE: Go ahead and give me your contact again.

MS. K. MILLER: Mine?

AUDIENCE: Yes, ma'am.

MS. K. MILLER: I have a card that I can give you.

AUDIENCE: Okay. Yeah. And I know one time we were given an E-mail address to send stuff to, and we just didn't get an answer back to some things. So we can send it to you directly now?

MS. K. MILLER: Yes. You can contact me. Any claims issues, those need to go through the hospital network mailbox. We have a new work flow process.

AUDIENCE: Because it was not working.

MS. K. MILLER: Well, I will admit, yes, we had some issues with that in the beginning. We have definitely worked through some things and we do have some internal support ladies that are helping to address those. Brandy and I travel quite a bit. So we certainly don't want to delay working on anything for you that's claim related. So that way we have a group of people that can start researching and resolving those issues. Please feel free to contact us on those as well, especially if it's not been addressed. But I do work through that mailbox as well or look through it every day to see what's happening. So things are flowing in and out of there all the time now. It is definitely much better than it initially started.

AUDIENCE: Okay. Go ahead and give me that E-mail address again. You'll give me a card.

MS. K. MILLER: If anybody has any claims issues, it's hospitalnetwork@bcbsal.org.

AUDIENCE: I just have a question about the MOON notice that must now be given to Blue Advantage patients. Will that now be part of the Blue Advantage audit process, that when you audit those charts, you're now going to be looking for that letter to see if it's part of the record?

MS. K. MILLER: I would say yes, because if that's something that once we get audited by CMS and we get dinged for it, they're going to be looking for that. I mean, I've not heard that specifically, but I would assume that. Yes.

MS. KIRK: Okay. The next hot topic, there was a webinar presented on February 15th regarding the in-patient procedures requiring pre-certification. I just kind of wanted to go over with you how to find that list. It is on provider access. Eligibility and benefits. You can look at the in-patient or you can go under surgical and you'll see the link. And it is listed as procedures requiring pre-certification list. Another way that I've told my facilities that you can also search it is in the search bar. If you enter that in, it will come up. But just please make sure that you are checking that list. It is subject to change. So just keep that in mind.

MS. K. MILLER: For the list that she's talking about, it's the possibly non-covered list for the facilities. We made sure that the physicians also have access to that list since they don't go into the manual and things like that. We have provided that specific list to them through benefits and eligibility. So if it is one of those possibly non-covered procedures, then the physician should be calling in to initiate that pre-certification because those procedures will be reviewed by Blue Cross. So we were trying to make sure that the physicians had the same information. We did a webinar that was for both facilities and physicians to call in so everybody could hear the same message at the same time. And if you did not participate in it, that will be posted online in the very near future. But when we do those, we do them live. But then we have to go back and re-record it. So that's what they're going through now is recording it so they can get it posted.

MS. KIRK: And as for the Hospital Choice Network, we are now using lower member cost share and higher member cost share instead of tier I and tier II. All the tier I and tier II service was taken off as of January 1st. At the current time, the hospitals are looked at. The 50 percent cost, the 30 percent quality and the 20 percent patient experience. So that is what the score card is currently based on. It's always subject to change, but that's what it currently is.

As for an opioid update which I know this is a big topic in Alabama, we're making great strides. So thank you to everyone for all of the hard work. It's currently down to short-acting scripts, roughly sixteen point seven eight days. The goal is to have it dropped to about seven days for a prescription. And just remember that Suboxone no longer requires a prior authorization. Are there any questions about any of that? Well, I thank you guys.

AUDIENCE: Do you anticipate any problem with our secondary claims with Blue Cross with Medicare numbers changing and processing them?

MS. K. MILLER: Like? Can you expand?

AUDIENCE: Well, the Medicare number is changing. And so in April they'll start getting new numbers. You won't have any problems with crossing them over to Blue Cross and processing them any differently?

MS. K. MILLER: No.

AUDIENCE: So we should not see any hiccups on those? Because it will be totally different.

MS. K. MILLER: I mean, never say never. I do not anticipate anything. But honestly, I don't know at this point. I haven't heard anything. But if you start seeing something, then let us know.

AUDIENCE: Yeah. This is going to be a totally different format. The crossover claims, how do you identify them? What do you identify them by when they come over from Medicare? Maybe that's why you're not panicking?

MS. K. MILLER: I have no idea. It comes over our feed.

AUDIENCE: Okay. Because that's a huge thing going on. Okay. Now, my next question was we got in one of the Blue Cross transmittals that there's a new program for autoimmune biological drug program. And what it said was there's a list of drugs that are preferred drugs that do not require a pre-certification if you choose from that list. But there's no list that I can find, I've looked everywhere. We need the list of the drugs that are preferred because if it is within that list, they don't need a pre-cert. But if they are not, then you do need a pre-cert. So where can we find that list was my question.

MS. K. MILLER: Did you check the pharmacy link online, because that's typically where they have those?

AUDIENCE: Pharmacy link?

MS. K. MILLER: Yeah. There's a pharmacy section on the website, and that's usually where you'll see that. I'm happy to send that to you.

AUDIENCE: Yeah. There's the list, you know, pre-op list, the regular one. Would it be the same? I don't know if it was the same or not.

MS. K. MILLER: I don't know if there's a separate list available online. I'm happy to look.

AUDIENCE: Because it's a new program they're implementing. It's called autoimmune biological drug program.

MS. K. MILLER: Okay. Is that something everybody probably needs?

AUDIENCE: Especially at cancer centers and outpatient infusion centers.

MS. K. MILLER: So I made a note. So we will get a copy of the list to Peggy to send that out to you. Anything else? Well, okay. Thank you very much.