BLUE CROSS MINUTES
November 7, 2016 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt

MR. ASHMORE: I'd like to welcome Kathryn Miller and Michael Lombardo from Blue Cross today.

I. Blue Advantage

1. Follow-up to Question #3 from July 18, 2016 RIC/RAC meeting that you asked to keep on the agenda for the November meeting.

With the release of CR9603 which requires the JW modifier for billing drug waste be assigned by the hospital will Blue Advantage require it as well? If so, could you offer guidance for the following:

Can the hospital bill for only the amount of the drug given and not the waste?

If the drug is wasted in the pharmacy (when mixed) and not by a nurse in the department the documentation usually is not located in the patient medical record of the waste. If requested for review, can the hospital supply documentation maintained in the pharmacy and not the patient medical record?

Response: **We will be following Cahaba and will not be requiring the use of the JW modifier at this time. If providers wish to designate that a portion of a single dose vial is being discarded, please continue to bill the injection on ONE line and add the JW modifier to the procedure code and document the discarded amount in the patient's records. Bill for the complete vial, even though part of the vial is being discarded. DO NOT split the billing to two claim lines: one with the JW and one without.**

This direction is in relation to Part B drugs and biologicals.

Discussion at meeting

MS. MILLER: We will be following Cahaba, and we are not going to be requiring the JW modifier. You can bill it, but it is not going to be a requirement. If you do bill it, just make sure that you put it on one line with your JW. Don't separate your lines to show what was used and what was discarded. And this is for Blue Advantage only, not for commercial.

MS. NORTHCUTT: When it says, we'll be following Cahaba and will not be requiring the use of JW at this time, so it is going to be required January 1 permanently, where we're going to have to actually use it?

So right now they're saying you can practice and you don't have to, but it's going to be a condition for payment in January. So we would love for you not to, but I don't know. That's kind of the clarity of that.

MS. MILLER: Okay. We're not going to require it at this time, so you don't have to put it on there.

MS. NORTHCUTT Great.

AUDIENCE: That's lovely that you don't; however, the problem is that we're having to do that for Medicare. So when you think about hospital billing systems, it's so much easier.

MS. MILLER: That's fine. I mean, if you're doing it for everybody else, you can report it.

AUDIENCE: Okay. But we'll be reporting two lines. Because this is how Medicare wants you to report it, one line without the JW modifier representing what you actually gave the patient, a second line with the JW modifier representing what was wasted. So when Medicare wants it laid out on the claim is not how you want it on the claim.

MS. MILLER: Understood. Okay. I'll have to take that back.

AUDIENCE: Okay. Thank you.

MS. MILLER: Sorry.

2. If the MUE for respiratory nebulizer treatment is two and the hospital performs more than two, can the hospital just bill the two treatments and not the others?

Response: **Yes, this would be the business decision of the facility.**

Discussion at meeting

MS. MILLER: So it's up to you. If you don't want to bill the remaining units that are done, then you do not have to do so.

II. Blue Cross

3. With the mandate of needing all CPT's attached to certain Rev Codes (278 is the biggest issue) or the claim will be denied, not a line item denial: How does BC recommend we handle those 278 items that have no CPT to add?

Response: **Based on the feedback from the July meeting, it was recommended that UB manual be used to determine if HCPCSS/CPT was required with the revenue line. Based on this recommendation, the UB manual does show a "y" for the HCPCSS.**

After receiving examples, we have decided to exclude both 278 and 68x for Trauma response due to the first 30 min not being able to bill the G code. Please remember if there is a code, please file because there could be times where there is separate reimbursement.

Discussion at meeting

MS. MILLER: We have added this one to our list. So as of November 1st, that front-end edit did go in for everybody. Please keep in mind that just because the edit went in does not mean that you are now going to be converted to EAPGs, because that doesn't happen until you renew your contract. But the front-end edit does go in for everyone. Certain revenue Codes are going to require the CPT codes to be with those.

We've updated the FAQ on-line. So please make sure that you go out there and take a look at the most recent updated version. We've also added the trauma response as well because of the G Code. If there's not 30 minutes or so of treatment, then you can't bill the G Code per CMS. So that one was added as well for the trauma response.

I know that the recommendation from our previous meeting was just to use the UB manual for the Revenue Codes to have the HCPCS or the CPT codes, and that's what we did. But then as we're starting to get calls or emails from you guys, we are finding additional Revenue Codes that don't specifically need a code, because there's not one available.

I will say if there is a code, please make sure that you are using the code and filing it because there could potentially be reimbursement attached to that. If the revenue line comes in without a HCPCS or CPT, then it will be allowed in the front door, but it will automatically have a zero dollar allowance on that line. So just be aware, if there is a code, please make sure you're using it.

4. Please provide documentation/guidance regarding "never events" for Federal Blue Cross. We have been getting denials but unable to find documentation with definitions of "never events".

Response:

- **The Blue Cross and Blue Shield Service Benefit Plan defines "Never Events" as "Errors in medical care that are clearly identifiable, preventable, and serious in their consequences, such as surgery performed on a wrong body part, and specific conditions that are acquired during your hospital stay, such as severe bed sores."**

- **The Blue Cross and Blue Shield Service Benefit Plan states that the Plan does not cover "Services, drugs, or supplies billed by Preferred and Member facilities for inpatient care related to specific medical errors and hospital-acquired conditions known as Never Events".**

- **The Blue Cross and Blue Shield Association's (BCBSA) Never Event initiative follows CMS guidelines, with one exception: while CMS exempts some hospitals from reporting HACs and the three wrong surgeries, BCBSA's Never Events requirements apply to all acute care hospitals other than VA hospitals. It is possible, though unlikely, that the BCBSA may add Never Events that CMS has not adopted, or may not approve Never Events that CMS adds.**

Discussion at meeting

MS. MILLER: Okay. The Federal Employee Program (FEP) is different than commercial. It is not processed up front and the claim pays and then, on the back end, it's reviewed. For FEP, they look at it up front. So the claim will always reject up front if you have a diagnosis code that falls on that list that is a potential adverse event. So what we're looking at internally is trying to clean up this process a little bit because it is a little bit confusing.

Because what typically happens is you file an appeal, that appeal goes to one area, and Never Events aren't typically supposed to be an appeal. It should be reviewed or an appeal on the member's behalf. If you want to appeal it, you need to write on your letter, "Quality Management for review of possible adverse events." That's going to get your records to the right department the first time. Because when it's looked at as an appeal, it ends up going to a couple of different areas. People are looking at it, and it's like, okay, this isn't our area for review. So then, by the time that it actually gets to the right area for the adverse events, it's been a couple of weeks, potentially.

So to be able to clean this up, this is what we're asking you to do, is just to at least go ahead and say that you want to send this to Quality Management for review of possible adverse events. So we're looking at potentially trying to maybe get a form or something to be able to streamline this and get it through the process quicker.

But I can tell you that it won't change as far as the claims rejecting up front for adverse events for FEP. At the end of the day, Washington makes their own decisions. We can get the records, we review it, we can make our determination as to what we feel we can make that recommendation to Washington, but they don't have to accept it. Most times they do. But if they don't want to accept it, then they don't have to, and they won't pay it. When that happens and they do say, okay, yes, we agree with you, we don't think this is an adverse event, then that claim has to process through FEP direct. So it's a little bit different, and it does take a bit longer to get that claim processed.

So FEP will definitely be different than regular commercial contracts as far as adverse events.

AUDIENCE: Kathryn, we've been working with you on this. I understand what you're trying to say is that there's no specific list like it is for commercial that says these are the Never Events. Is that a true statement with FEP, first of all?

MS. MILLER: That's correct.

AUDIENCE: And even if we had a list, everything in it will first kick back, front-end to say it has to be reviewed. And then case by case they'll be reviewing this?

MS. MILLER: That's correct.

AUDIENCE: And usually how long has it been? It's taking a long time, it's not just a little bit additional time. So what is their turnaround time? So what are we expecting here, 60, 90?

MS. MILLER: Well, on the few that I've been working for your facility specifically, I can tell you it didn't go to the right department the first time. So that has been part of the reason why this has been delayed. It may have gone to medical review, medical review looked at it. But that's not really the right area that's reviewing these. This is our quality management area. And then once they review it, one of the associate medical directors also reviews it. Then the medical director makes the determination and

then reaches out to Washington to let them know. So part of the problem has been that it didn't go to the right place the first time.

I mean, I've been working with Baptist, so this is what I'm speaking to. Also, when I got the records, they were separate. One was in a box, and one was in an envelope, so they were mailed separately. And I thought it was all in one box together, so they weren't reviewed at the same time.

AUDIENCE: So we still go through you or whoever the provider rep is, I guess? You know, each provider do that, go through you?

MS. MILLER: You can.

AUDIENCE: And then when you say Quality Management review of possible adverse events, that's how you address it?

MS. MILLER: Yes. And that should get the records to the right department the first time.

AUDIENCE: Okay. Thank you.

MS. MILLER: So that's what they specifically ask me to have you put on there so that if it comes in and claims gets it, they don't turn around and send it to medical review, then medical review looks at it and says, no, I'm not the one that looks at this, and then they send it to another area. So we're just trying to bypass all of that and get it to the right area the first time.

AUDIENCE: So when we mail all of that, is there a specific address?

MS. MILLER: You can still send it to the same address. You just need to make sure you have Quality Management on it. They're going to know where that goes from that point.

5. If the MUE for respiratory nebulizer treatment is two and the hospital performs more than two, can the hospital just bill the two treatments and not the others?

Response: **Yes, this would be the business decision of the facility.**

Discussion at meeting

MS. MILLER: So this is going to be the same as it was for the Blue Advantage for commercial. It's going to be a business decision. It's up to you if you want to write those off or if you want to bill those.

6. Please provide presentation on appropriate billing, coding and documentation guidelines on HCPCSS J1439 Injectafer.

Response: **We are following manufacturer guidelines and you should have documentation in the medical records.**

Discussion at meeting

MS. MILLER: We do not have a medical policy on this, but we are going strictly by the manufacturing guidelines. So you need to make sure that the medical records do reference that the member has either tried oral iron or they have an intolerance to it. There's got to be some type of documentation that does refer to that. It can't be a first line of medication. You can expect those will go to medical review each time. They are going to request the records, and that's what they're going to be looking for.

But you can go straight to the manufacturing website, and it specifically lays out what it's for. And I wrote it down, so I'll just read it to you. So it's indicated for treatment of iron deficiency anemia in adult patients who have intolerance to oral iron or have had unsatisfactory response to oral iron in adult patients with nondialysis dependent chronic kidney disease.

So just make sure that there's documentation in there that the member has either tried oral iron or they have some type of reason as to why they can't take oral iron.

MR. ASHMORE: Okay. If we don't have any additional questions, we'll move on to the presentation portion.

(PowerPoint presentation)

MS. CARSTENS: I am going to make the presentation available on the website because I know the handouts were very small. So you'll actually have the PowerPoint presentation available to see it.

MR. ASHMORE: Thank you, Kathryn and Michael for coming today.