BLUE CROSS MINUTES
March 7, 2016 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt

MR. ASHMORE: I would like to welcome our presenters here from BlueCross, Kathryn Miller, Michael Lombardo, and David Posey.

And we're going to go through the four questions, and I'm going to hold the Q&A until after Kathryn does her presentation.

1. Follow-up to Question #3 from November 9, 2015 RIC/RAC meeting for Blue Advantage
a) Hospitals are receiving numerous post payment DRG audits (**not** risk adjustment). We submit the medical records as requested, but we are having trouble getting the audit findings. We have been told that no results mean no findings. However, denials can get lost and appeal time is limited. It is extremely burdensome for providers to have to constantly check specific claims for recoupments for a year or more to ensure that there are no take backs. Will Blue Advantage provide a contact person or a website or a letter that will give a result of the audit findings so that these claims can be closed?

Response: **Cotiviti has a dedicated Blue Cross and Blue Shield of Alabama unit. You can call for status on records received or an appeal. The direct number is 203-202-6038. They are available Monday-Friday 8-5pm EST. They do have secure voicemail, so you can leave a message for a callback. If you are concerned about leaving patient information, you can leave the patient control number and they can access the patient without the name/dob.**

Discussion at meeting

MS. Miller: Yes. We are going to start sending out a letter. And I'm going to go over that in much more detail in the presentation because I do have a whole section on Cotiviti.

We did have them on site last week. We had five members of their team. We had their operational level managers, directors, VP, and senior VP, so I had the floor to make sure that I addressed your concerns because I do understand the frustration there. So I did address it with them, and we are going to start getting letters for those, you're still going to get your rationale letter, but you're going to get a closeout letter too on the ones that they do not have any findings on. So that's been addressed.

MR. ASHMORE: Can you confirm with us when this will begin?

MS. MILLER: This should start in April.

2. We are continuing to receive letters from Connolly/Cotiviti stating “Final Notice For Failure To Return Records”, when the records have been submitted timely by our institutions via FedEx and for which we have signed confirmation of delivery. Connolly/Cotiviti advises that they are

"probably just behind in processing them again". Can Blue Advantage address timeliness of records processing for records being received at Connolly/Cotiviti to prevent delinquency notices and to prevent expensive technical denials?

Response: **Cotiviti was recently onsite and this was part of the discussion.**

Discussion at meeting:

MS. MILLER: Yes. This was another topic that was addressed while they were on site last week. And I'm not sure how many people are utilizing the health port option, but they do have a way to receive those records electronically.

Another thing that I wanted to do is check and see if there are any facilities that would like to update their address if anybody is having an issue of it being delayed getting to their area, because I know Cotiviti was using the correspondence address that we had on file for the facility. So if you want that to go directly to one specific area, if you want to send us an update with the address, I can get that sent to Cotiviti, and they will send that out next month with their request.

3. Follow-up to Question #5 from November 9, 2015 RIC/RAC meeting for Blue Cross
Will Blue Cross consider reversing the original payment on the same remittance when they pay a corrected claim? Not reversing the payments on the same remit causes credit balances on our accounts and also causes us extra work having to go into the Blue Cross system and work the accounts on the Refund Billing Invoice Claim Auto Deduction Refunds page.
This is still not being done.

Response: **When refunds are keyed, the intention is to keep them on the same remit. Any bulk refund that is created is always started on Monday. If the entire bulk doesn't adjudicate by mid-day Thursday, then it will not be on the same remit. There are many different reasons that the bulk could suspend out and require information to be updated before it adjudicates. There are times when it's outside the analyst control. FEP is always going to be a little bit different and take longer because the pricing is handled through FEPdirect in Washington. Everything has to be approved through them before we can finalize the refund process, so the majority of those will be on split remits.**

Discussion at meeting:

MS. MILLER: I met with Claims, and we did have a long discussion on the refunds not going on the same remits. Part of the problem is you have an area like FEP. And when those get refunded, they go to Washington, and we have to get an approval through Washington before we can adjust those claims. So those, for the most part, you're not going to see on the same remits.

When they do the bulk recalls, they're required to start those recalls on a Monday. If those do not adjudicate by 2:30 on Thursday, they're going to be on the following remit. There may be a reason that they have to go out there. If the claim suspends, then they have to go out there and manually add some information. So if that happens to take place after that Thursday at 2:30, there's no way to ensure that those are going to be on the same remit. But what I can do is provide you guys a little more

communication up front so when I know a large bulk recall is going to take place, I've already touched base with the CDSA area that's responsible for those, and they're going to let me know before they do any type of bulk recall, and I'm going to set up a list serve for all the facilities so that I can push out information to say, hey, this is just a heads up to let you know FEP has got 8500 claims that are going to be recalled on the following remit. So even if I can't guarantee they're on the same remit, would that help for you to at least know in advance this is coming?

AUDIENCE: It would help except for the fact that we have to manually go in and check the box in BlueCross's system that tells BlueCross to take the money back.

But my other question is why don't they just pay it and take the money back on the same remit? If they've got to have approval for a refund, then just don't pay it until they get that approval as well.

MS. MILLER: Okay. We have two different things going on. So with the refund billing invoice, sometimes you may be paid twice before it comes back. They do not have audit deducts set up across the entire network because not everybody may want it auto deducted off the remit. So it goes through that 45-day billing cycle.

So if you knew it was a bulk recall, instead of having to go out there and look at each individual one, could you wait the 45 days and let if come back?

AUDIENCE: No. I don't want my credit balance sitting out there for 45 days.

MS. MILLER: Here's the next question. I talked to the CDSA area about this, and they did say that there is an enhancement that they could do, and they could set up an auto deduction. But I needed to get feedback from all of you and find out who wants auto deducted and who wants the refund billing.

So if everybody decided on, okay, we're okay with the auto deduction, then I could have them move forward with that. It will take a little time for programming. So it could be, you know, much later; it could be Q4 this year or Q1 next year. But if that's something that everybody was in agreement upon and would rather go that route, then we can do that.

AUDIENCE: So the suggestion might be that we vote on that and present that to you as a group, and we can do that in the future if everybody agreed with that?

MS. MILLER: Yes.

AUDIENCE: Okay. But would it have to be as a group, or could you do it individually as a facility?

MS. MILLER: We could not do it individually. Because when they set up the bulk recalls, it goes out to the entire network. They can't go in there and do it manually for each facility.

Now, if there was a bulk that was specific to one facility for one specific reason, yes, we can absolutely do that. But if it is something that affects the entire network, we can't do one office.

AUDIENCE: In the case of a bulk, could you just automatically do a refund on the following remit rather than having to hold it for 45 days when it is not request, it's something like FEP did to us? They just took back several hundred claims.

MS. MILLER: I understand.

AUDIENCE: And not have to wait 45 days for that to be corrected?

MS. MILLER: I'll have to get the feedback and see what the group says as a whole. I definitely do not mind taking it back and saying, yes, this is something we want to do, and get that programming started. That's not a problem. But if not everybody wants the auto deduction, then we're not going to just put it in the system.

AUDIENCE: Well, but if it's a bulk, and we didn't initiate it, it would seem like they would want to get their money back? That's the other question. Wouldn't logic tell you that BlueCross would want to get their money back as fast as they could?

MS. MILLER: We do. But we don't have any way to put that in right now to say, hey, we're just going to take it back and not give you an opportunity.

AUDIENCE: Well, it used to be that way a long time ago. Ross probably remembers that. He's been around a little while.

MS. MILLER: Okay.

4. Has anything changed through the years or is this still a valid statement:
When a patient is seen twice in 24 hours (same date of service) the account need to be combined as it would reject at B/C for overlapping dates of service.
When a patient is seen twice in 24 hours, with different dates of service (1/02/2016 & 1/03/2016) and a different diagnosis, the accounts can be billed as two separate claims.

Response: **This is still an accurate statement; however it could depend on the services being rendered if it will need to be combined or if it could be billed separately.**

Discussion at meeting

MS. MILLER: There's not really a perfect answer for this. It's, yes, it is still a valid statement, but it's also going to depend on the services that are being rendered. Because if you've got two different ER visits and you've got the same diagnosis, yes, you probably need to have those combined. The different

diagnoses, they can be split. So it's really going to depend on those services that are being rendered. If it's two completely different services, two completely different diagnoses, there is a hierarchy in our logic that those should not duplicate.

Now, that doesn't always happen, because if you have somebody that's manually processing something, you may have somebody that projects that in error. But again, it depends on the specific services. And without having any examples, if whoever submitted the question, if they would like for me to review any examples, I'd be glad to do that.

PowerPoint Presentation by MS. MILLER

Okay. Cotiviti was in house last week. And we did discuss in detail that you're not getting any type of follow-up when you're submitting an appeal or you don't know whether or not they found anything. Because in the past, if they didn't find anything, they didn't send anything out.

And the reason why is because if you got a letter that said, hey, we didn't find anything, then you can't assume that this member is closed out for all audits. So if you get a letter that says, okay, we didn't find anything, that's just for the DRG review. We can still use that member and any other type of audit that could potentially come up. So that's why they didn't send a letter out in the past. But we did say, no, we want you to send a letter out, but you need to have that disclaimer that that means that the audit is just being closed out for the DRG review. Okay? Not medical necessity, just the coding part.

So now you're going to start to get monthly cycle letters of these members of who they reviewed throughout that month. It's going to be one letter. It's going to give you the generic verbiage to say, hey, these are all the members that we reviewed this month, we agree with you, we're not going to be pulling anything back. So that's just going to be a closeout letter, and then it will have a list attached with all of the members.

Now, I do want to hear your feedback on that. It is supposed to start in April. So if you are not getting those letters or if they're not sending them with the appeals, then please let me know that, because I am tracking that very closely because they will be coming back on site in a couple of months, and I do want to make sure that I'm addressing that with them.

AUDIENCE: How do they need to let you know that?

MS. MILLER: Send that to your normal provider rep, and they will forward that information to me. Okay? So they're all going to be aware that if they get anything about Cotiviti, they're going to send it to me.

AUDIENCE: I have a question. Who will the letters go to?

MS. MILLER: Well, that's another reason why I was asking if you wanted to update your address for the facility. So if you want that to move to a specific area, then I would also recommend, when you give me the address, don't put a specific person's name on there. Because people move jobs, so you don't want it to be tied to one person. So I would say, you know, attention HIM or attention medical records or attention whoever you want it to go to and put their specific address.

So this won't change the correspondence address for the facility for all other information that we send out, this is strictly for Cotiviti. Okay? Because I know sometimes it goes to a generic area. It happens at BlueCross too. And you're a large facility. We're a large company. And it takes time to get it to the right area that it's supposed to be at. So we want to make sure that we've got the correct address to be able to get you your information.

Appeals. Make sure when you're filing appeals that you're submitting additional information. If you're not submitting anything additional to say why you feel like it should be at the DRG that you filed it at, then it's not going to be reviewed. So when you get to that third level review and you're just getting your answer and then turning around and saying, hey, I need a third level appeal, it's going to be closed out automatically. So if that's happened and you have additional information, you can file that with additional information only.

And the appeals finding letters, I'm going to be tracking those as well. So just kind of keep me in the loop, keep your rep in the loop to say, hey, I'm still not getting this information.

Status. They do have a dedicated BlueCross unit. Well, here's a copy of the letter that will be going out. There's a phone number at the bottom right here that is a dedicated BlueCross unit. So if you want to call them and find out have you received my records, have you even gotten to my appeal yet, this is dedicated just for BlueCross. They do have secure voice mail. So if you need to leave information there, you can. It is not going to go to any other area of Cotiviti. This is, again, strictly a BlueCross unit.

These are all the different ways that you can send your information to Cotiviti. If you have a relationship with Healthport, I highly recommend sending your information electronically, and it will be a much quicker process.

Exchange plans. How many people have had people come in with the MSP plan that you know of? I've been getting a lot of questions about that lately. There are two new products that came out, and it is on the exchange and off the exchange. And you'll see MSP at the end of it. And they're called multi state plans.

So in order for the facility to have benefits on these contracts, this requires a primary care physician to be chosen for each one of the members.

Now, the facility does not have to have a referral, but you do have to make sure that the member has already chosen a PCP. So if they've not chosen one, your claim is going to process as out of network, and it will not be covered. And I'm going to show you on provider access where they've chosen a PCP.

Now, the product does require a referral on the physician side only for specialists. Okay. So they have to choose a PCP, and the PCP is going to be from a group of physicians that we've got online that's the primary care select. And they have a star by their name, so they'll know which ones they can go out there and choose from.

So for those of you that bill for physicians also, you're going to want to take a look at the referral process, because all referrals are going to have to be done online, and retros are not allowed. We do have a 72-hour window. So if they come in today, they should have already had a referral on the system, the PCP has got 72 hours to get it in. But after that 72 hours, there is no other retro process.

Now, if you do any billing for the specialists, this is how you would go out there and take a look on provider access to see if the information is out there. Okay? You log in to provider

functions. There's a section called Primary Care Select Physicians. You can review a referral, you can submit a referral, you can update the covering physicians, and then there is an activity report.

Because a lot of physicians don't even know that the patient has actually gone out there and chosen them as their PCP. So there's a link where you can go out there and run the report, and they can see exactly which patients have them listed as their PCP.

So when you go under each one of those links, you have your covering physicians. If you want to review the referral, you can look at the referral by contract or you can look by the specialist. And if you're entering the referral, this is all you need: contract number, the NPI number, the begin and the end date. So all that information is out there if you need to check to see if a referral has been done before the services.

So now we have a couple of products that are Primary Care Select. One, you have to have a referral or it's not going to be covered. The other one, you have to have a Primary Care Select physician just to get a reduction in the copay. And if there's a referral out there for the specialist, then there is a reduction in their copay as well; otherwise, it's still covered. So you really need to make sure that people are going out and verifying benefits and eligibility so you know which plan it is and if you need a referral or not.

So this is where you're going to look on provider access. You go under the benefits section or go under Provider Functions, you put in the contract number, and this right here tells you primary care provider. Over here to the right it says select physician not designated. So if this person came to your facility and they were having surgery, it's not going to be covered because they have not chosen a PCP.

Now, they can go on their smart phone, they can pick somebody right then, they can call customer service, they can choose that option; but, no, when these members signed up for these plans, we sent a letter out to them along with their card and said call customer service as soon as you get your card. So when they call customer service, they go through the benefits with them, and they've tried to make them pick a PCP right then on the phone so they can at least have somebody listed. And they make sure that they understand they have to have a PCP.

So if by chance you get somebody that doesn't have a PCP, your claim is out of network, it's a member responsibility. It's not a write-off.

(PowerPoint concluded)

Additional discussion at meeting

AUDIENCE: Will we be able to have more than one administrator?

MR. LOMBARDO: Yes. You can have several master administrators, you can have other administrators which are similar to the master administrator, and you can have as many users as you want, yes. And I would recommend that you do have more than one master administrator so that you don't have just one person responsible for all of that administrative work.

AUDIENCE: Do you have any EAPG education events planned?

MS. MILLER: We're actually going through the programming of that right now. July 1 we thought would be the first time the facilities were going to transition to that, but the programming is

just not going to be completed by then. So 10/1 is going to be the earliest time period for that. So at our next meeting, we'll be far enough along, I'll bring information on EAPGs, and that will be part of the presentation for next time.

AUDIENCE: Thank you.

AUDIENCE: Back on the multi-state plan, the two that you're adding, do you have three letter Alfa-prefix specific that you could provide? Because we do use a vendor.

MS. MILLER: I can give you that. But still make sure at some point somebody reviews it. Because the BEG and TCA, some may be on the exchange, some may be off the exchange. So you really need to look at that.

AUDIENCE: Right.

MS. MILLER: Because those prefixes also cover some of the other on and off exchange plans that don't require the referrals. Those are the two prefixes.

AUDIENCE: I think we were concerned about pulling them out like at reservation points so that they could be reviewed by that prefix to see if they are on the exchange.

MS. MILLER: Well, here's the other thing. BEG and TCA will be through the exchange and off the exchange if they purchased it from us directly. Now, you will have some small groups that end up getting this plan in the future. When they do, it may be an XAA, it could be a PPA. So I mean, I can give you the general two, but at some point, you may have an XAA or PPA contract with that. So you need to be careful with that.

AUDIENCE: You say that when we submit the codes to the BlueCross on our claim, your system is going to sequence them and pay them based on the DRG that the BlueCross system finds. What if you have two co-equal principal diagnoses? Typically hospitals are allowed to sequence those as they prefer. What if your system doesn't sequence it to the same DRG that we have coded?

MS. MILLER: Well, first of all, I've not had that come up so far. So if anybody has some examples, I would love to take a look at that and see if it changes anything. But we'll just have to kind of go through it at the time when that happens to see how it changes it.

AUDIENCE: Okay. And on the quarterly rescoring, is that something that will be automatically initiated, or is that something providers have to request?

MS. MILLER: It will automatically be done. When CMS updates their website, then we'll go back and rescore. And it's based on their hospital compare update.

AUDIENCE: Okay.

AUDIENCE: For the cost analysis and readmissions, what date range will it analyze in the rescoring?

MS. MILLER: I don't know. Does CMS give the date range? Because we're going to use the same date range that they're going to be using when they update.

AUDIENCE: The only thing that you are using from the CMS website is the HCAHPS scores. You are taking your own claims data and giving us a readmission score and the cost score.

So what we are wanting to know is what date range you are using. I'm assuming that April 1st, it will be reviewed for a rescore. So how far back are you going to go? What sample will be pulled? Is that something you could check on and get back to us?

MS. MILLER: I can.

AUDIENCE: How are you handling your POA indicators now when they hit a claim? You know, in the past, we would do maybe a root cause analysis, and if we had done due diligence at the facility, that claim would roll out, or if we determined it did not increase the length of stay of that patient, we were able to go ahead and bill for all those days. But now if the claim has a POA indicator on it, it's a hiccup as far as the billing or our payment?

MS. MILLER: So you're talking about adverse events, correct?

AUDIENCE: Yes.

MS. MILLER: So what's going to happen is that claim is going to reject out if there is a POA indicator that's on that list. So once that happens, our HM area gets a report of those, and then they will go and review them. They'll ask for records on the back end, and they'll review it and see if they feel like there's any additional days or anything within that time period that shouldn't have been billed.

If they look at the records and they say, hey, no, everything is good here, then they're going to allow it to process. They'll go back and pay the claim. If they disagree, then they're going to contact the facility and they're going to kind of have a discussion there on why they feel the way they do on that. Okay?

Now, FEP is a little bit different, because I have to work on a couple of FEP lately. And FEP, that, once again, goes to Washington. And Washington doesn't care what we have on our local system. So they make the decision. We can give them guidance and say, hey, we had a peer-to-peer with our medical director of BlueCross and the medical director from the facility, we don't feel like that this is an actual POA, so we can give our recommendation. But it's ultimately their decision, and then we have to do a manual processing on the back side that doesn't really go through the claims system for FEP.

AUDIENCE: Okay.

MS. MILLER: So those you're always going to probably contact your rep on.

MR. LOMBARDO: And I want to add one more thing about the website. We don't have a firm date as to when we're cutting off the old website, but I know that it is quickly approaching, so please contact us as soon as you can. Because I'm afraid that once we open the floodgates and we're not trying to help you one-on-one, it's going to become crazy. So if you want a little personal guidance with the systems to get registered, please contact us as soon as possible.

MR. ASHMORE: All right. I'd like to thank Kathryn Miller, Michael Lombardo, and David Posey for being here today.