BLUE CROSS MINUTES
July 18, 2016 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Debbie Rubio

MR. ASHMORE: With us today we have Kathryn Miller and Amber Williams from Blue Cross. Thank you for being here today.

MS. MILLER: Thank you for having us.

I. Blue Advantage

1. Follow-up to Question #1 from March 7, 2016 RIC/RAC meeting in regards to Cotiviti and the closeout letters. Have the closeout letters been developed and sent out to providers?

Response: **Yes, the letters have been going out since April. If you aren't receiving them, please let your Provider Consultant know along with the correct address of where it needs to be sent.**

Discussion at meeting

MS. MILLER: I have received notification from several providers that they have been receiving those. So if you're expecting to be receiving one based on records that you've submitted, if you've not heard a response, please reach out to your provider consultant and let them know that you are not receiving your monthly letters. Because it could be going to a different area at the hospital, and we may need to update the address or where it needs to be going in your facility. So is anybody here today not receiving those?

(No response)

MS. MILLER: No. Okay.

2. Effective January 2016, the MUE value for CPT code 94640 (Airway Inhalation Treatment) was changed from ten to two units. The past instruction for reporting units of 94640 from the CMS NCCI panel stated:

*"Your inquiry requests clarification about the units of service that may be reported for this CPT code **94640** on a single date of service. A provider may report only one (1) unit of service (UOS) for a professionals (e.g., respiratory therapist) visit to provide services reported as CPT code **94640** even if those services require more than one inhalation treatment (e.g., multiple medications) at that encounter. The professional does not have to provide continuous face-to-face service during the entire treatment time but may initiate the inhalation treatment and return to continue or complete it.* ***If the professional completes the inhalation service(s) and***

terminates the patient encounter but returns later that day to initiate additional inhalation treatment(s) reportable as CPT code 94640 an additional UOS of CPT code 94640 may be reported for this subsequent patient encounter."

With the update to only 2 MUE units, do we continue to use modifier -76 for each additional treatment?

Response: **The MUE value of (2) is a *date of service* edit. If additional units of service are needed, the claim would have to be appealed with medical records. The modifier "76" would not be used for this scenario.**

Discussion at meeting
AUDIENCE: We just had Medicare say that we need to use 76.

MS. MILLER: I had looked that up as well. And it said since it was a date of service edit, that those actually have to be appealed with records; otherwise, you have to write to NCCI to have them review the edit.

AUDIENCE: They did say submit the medical records. But they also said use 76.

MS. MILLER: Okay. Well, I'll have to go back and have that re-evaluated.

AUDIENCE: Okay. Thanks.

MS. RUBIO: That was the point that I was making to Cahaba. You can put the 76 on there all you want to; but if you exceed two units, it's going to have to deny.

AUDIENCE: You have to, yeah. So I'm wondering if it's even correct to use 76 for Medicare.

MS. RUBIO: To put the 76 on there is fine. It is a repeat on that CPT code instruction. It's just how it's going to process. The 76 is not going to bypass the edit.

MS. MILLER: Right. It's going to have to be reviewed with the records. Even if you put the 76 on there, it's going to stop. Does that help?

AUDIENCE: Yes.

3. 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 are in the process of reviewing this information and the implementation date is not until 1/1/17. I will not have a final answer until later in the year. We can have this on the agenda again for the meeting in November.**

Discussion at meeting

MS. MILLER: So as of today, we do follow Medicare, so we will allow for the JW modifier to be filed; but it doesn't go in until 1/1, so we have not actually made our decision internally yet at this point on reimbursement of that. So I won't be able to give you an updated answer until November. We've not had a chance internally to meet, review, and make that decision. So we'll just keep this on the agenda for the next meeting.

II. Blue Cross

4. Follow-up to Question #3 from March 7, 2016 RIC/RAC meeting for Blue Cross

regarding reversing the original payment on the same remittance you pay a corrected claim.

After polling the providers, the consensus was that they prefer the recoupment be on the same remit when you pay a corrected claim.

Response: **Based on the Love Settlement we had edits programmed so the claims would go to refund billing. We are going to remove those edits however it won't go into production until Q1 of 2017. We do have a manual work around right now, and I'm sure many of you have already noticed this starting to happen on your remits.**

Discussion at meeting

MS. MILLER: How many of you have already started noticing this on your remits? Anybody?

(No response)

MS. MILLER: I know after our major discussion last time, this was something that I have been working on internally. And the reason why things started going to the reimbursement area for the refund billing was because of the Love settlement. So now that that has expired, we can remove that edit and we can auto deduct. However, that was hard programmed into our system, so we have to go out there and remove those edits. And we can do that, and we are in the process of that, but it's not going to be until Q1 of next year before that's put into production. We do have a way of working around that right now. It's just a manual process. But I know there's many, many providers that have already been contacting me because we're already starting to get those taken care of on the same remits. It may not be in every circumstance, but we're trying really hard right now to make sure that it is done manually.

AUDIENCE: So are you saying it's started already and some should have seen it?

MS. MILLER: Yes.

MR. ASHMORE: Okay. Any other questions?

(No response)

5. When will Enhanced Ambulatory Patient Grouping (EAPG) training be offered? What information is available to assist hospitals with preparation for the new EAPG payment methodology?

Response: **We hosted a webinar that took place on May 24th. We have added a new page on the website specifically for EAPGs. There isn't specific individual training for facilities. We have a dedicated email box for providers to send questions, and at this point, we have not received many. We have developed an FAQ document and working on hosting another webinar that will be geared more towards the billing office. Please make sure that you are going through the EAPG hospital package that was sent to each facility and let us know what questions you may have. Each facility will be responsible for purchasing the 3M software if they want a desktop calculator and the proprietary information. 3M has made the definitions manual available to all facilities for 6 months. This manual explains the standard logic for grouping 3M EAPGs as well as the standard consolidation and packaging logic. You can sign up for this anytime between July 1 and December 1.**

Discussion at meeting

MS. MILLER: We had a webinar on May 24th. How many of you guys participated in that?

(Audience members raise hands)

MS. MILLER: A handful. Okay. The presentation is available online. We actually have a page on our new website that is dedicated specifically to EAPG. So we'll see in the presentation where you'll need to find that information online. But if you did not have a chance to participate in that, I highly recommend you go out there and pull those presentations and take a look at those.

We also have a dedicated email box set up for you to send your specific EAPG questions. That's going to go directly to a professional reimbursement area, and they're the ones that are answering those questions.

We're not going to have one-on-one dedicated facility time for each facility to go over EAPGs. We plan on having another webinar geared more towards your billing areas. So when that is finalized, we'll send out a notification saying, hey, we're going to have a webinar, this is what the date is going to be. And everybody would need to go out there and register. And we'll try to get that taken care of through a webinar.

If you have questions, please, please make sure you're utilizing that mailbox. Because right now I work with that area on a daily basis, and we communicate about this all the time, and they're saying

that they're just really not getting a lot of questions right now. And I'm wondering if that's because people haven't had a chance to go through their packets they received. We sent out a facility package to every single hospital with specific reports. I don't know if it's because people haven't had a chance to go through those, understand what the reports are, and they just haven't come up with questions yet. But at this time, there's only been a handful. I highly recommend you take advantage of that, send your questions there.

Also, 3M is going to allow six months of free access to the definitions manual, it's going to be six months from the day that you sign up. This starts July 1st through December 1st. So make sure you go out there and you sign up for that definitions manual. Once that goes away, any of that proprietary information goes away and we cannot, as Blue Cross, give you that 3M information. The definitions manual is going to have the methodology listed in there. It's going to have the logic. So this would give you an opportunity to go out there take a look at the definitions manual. And if you have questions from that, you can either, again, send it through that mailbox or you can contact 3M directly. And I've got their contact information in the presentation as well.

AUDIENCE: Can you give me some direction on why we are having to provide invoices for blood products for outpatient billing?

MS. MILLER: I know part of it has to do with they have to see where the blood is coming from. I know there are some banks that provide it for free, and we have to know what those situations are. There could be other reasons, but I'm not sure. We can add that to the agenda and talk about it next time.

AUDIENCE: Okay. At UAB, I think our blood all comes from the same place. So it seems like we could just answer in that way without having to provide invoices on every claim. So we can't get a claim paid without sending an invoice?

MS. MILLER: Right.

AUDIENCE: We give a lot of blood to patients.

MS. MILLER: I understand.

AUDIENCE: So you think put it on the agenda for next time?

MS. MILLER: We can do that. I know that we've been emailing about that back and forth. Does anybody else have issues with blood?

AUDIENCE: So nobody else has to provide invoices for blood products?

(No response)

AUDIENCE: That's interesting.

MS. MILLER: No. Everybody has to provide. That's going to be an automatic. When that comes in through the system, that's going to reject out automatically. But I think y'all just started billing that on 1500 as well, right?

AUDIENCE: Yes, that would be true.

MS. MILLER: Okay.

AUDIENCE: So on the UB billings, it's not a problem; only on the 1500 billings?

MS. MILLER: On UB billing, we don't look at things line item. There are times when there are medical policies where we have things edited, but not every single thing is, which is something that EAPGs will address. But again, if nobody else is having issues, then why don't we just handle that.

AUDIENCE: Okay. Thanks.

MR. ASHMORE: Any other questions?

(No response)

MS. MILLER: Okay. So now we're moving on to the presentation.

(PowerPoint presentation)

AUDIENCE: The question that I have is that not all items, for example, like supplies, have a code to go with it. So we'll have revenue code 272 that will just be one line with the quantity and the amount that we're charging. So you're saying that's going to get rejected? Because there is no code for a lot of those items.

MS. MILLER: Okay. For the transcribing, on the EAPG's, for the revenue levels, such as 270, to have the CPT code required to process, is that what you're asking?

AUDIENCE: 270, 250.

MS. MILLER: From my understanding, we have been told that there are codes to be submitted with the 250.

AUDIENCE: But not all of the items or even the medications that we use have HCPCS codes attached to them or that are associated with them.

MS. MILLER: Now, there are some low-cost drugs that will have a zero dollar allowance because they're going to be included with the main procedure. I actually don't have a list of what those codes are. It is in the main presentation from the webinar.

AUDIENCE: So we're going to have to attach these codes to our charges? Like a generic charge, we're going to have to attach the charge that you're talking about?

MS. MILLER: I would have to see what the code is and see if it's on that list.

AUDIENCE: All right. Because we have like 26,000 charges.

MS. MILLER: Okay. I'll need a specific example for us to run through and look at.

AUDIENCE: Okay.

MS. MILLER: Thank you.

AUDIENCE: Everyone has this problem.

(Affirmative response)

MS. MILLER: I understand.

AUDIENCE: We have separate line items for these other revenue codes that you say will not be processed. So if the claim is processed with that revenue code, we understand you won't pay for it. That's okay. We just need to claim the process through. So I think that's the dilemma.

(Affirmative response)

AUDIENCE: We have these 250s and 270s on the claims. We just want them to process through.

MS. MILLER: Okay.

AUDIENCE: Because for us to change that, that's huge. You know, that would be very difficult. So that definitely needs to be addressed.

MS. MILLER: Okay. So if somebody wants to send that either through and put it on the agenda for next time, we can discuss it then. Also, I would suggest you also send it to that EAPG mailbox for professional reimbursement to get that as well, because we're going to have to have examples to be able to look at.

AUDIENCE: Why do you need examples? You just need to know revenue code 250 and 272.

AUDIENCE: And 258 is another one.

MS. MILLER: Because if there's more than just the 250 and 270, like she said, I wouldn't know which revenue codes you're wanting us to look at. So I need to know a list of the revenue codes.

AUDIENCE: Well, that's the two big ones right there.

MS. MILLER: Thank you.

AUDIENCE: 258. I mean, there's several of them.

MS. MILLER: Okay. That would be great. Thank you. Also, you know, we've been advised that there are codes. So I'll have to get the information that we were provided from 3M as to what would be submitted there. So I'll be glad to put that in the presentation next time.

AUDIENCE: I have a question. Like the out of state, have they already started to implement this edit? Because we got a rejection on one of our claims for this reason.

MS. MILLER: Is it Blue Advantage or is it Blue Cross?

AUDIENCE: It's Blue Cross.

MS. MILLER: It's commercial?

AUDIENCE: Yes.

MS. MILLER: The edit hasn't been put in yet, so I will have to look at that.

AUDIENCE: It was for an out-of-state plan, though, and the home plan was telling us that this was the reason for the rejection.

MS. MILLER: But it has not been coded yet, so I'm not sure that that's the reason. I will be more than happy to look at it.

AUDIENCE: I can send you the example.

MS. MILLER: Okay.

AUDIENCE: I think the easy answer to this dilemma is just to go to the UB 04 manual, and it lists which revenue codes require CPTs and which are situational. And that would answer our dilemma.

MS. MILLER: Thank you.

AUDIENCE: Could you clarify the timeline?

MS. MILLER: So EAPGs will be implemented on 10/1. This edit for the revenue code would go in on September 1st. Oh, okay. I see what you're saying. Because they're not going to be implemented and our next meeting isn't until November. Okay. So what I can do, if Peggy will agree, then I can get the answer, I can send it, and then it can be blasted out to everybody. Does that work?

AUDIENCE: That works.

**** Information received 7/20/2016 from Kathryn Miller****

Based on the feedback at meeting this past Monday, I was able to have the communication pulled regarding the front end edit requiring revenue codes to have a cpt/hcpc. You will see official notification come out later today or tomorrow on the edit. Below is the list of revenue codes that will be excluded from the front end edit that goes into effect on 09/01/2016.

250-258, 270-273, 370, 710, 990-999

Please note that there are some hcpc/cpt codes that can be filed with these revenue codes. If there is a code, please make sure to include it on the claim for the most accurate processing.

Also, I've had questions about this applying to every facility since they do not transition to EAPGs at the same time. The only difference that you will see, is your remit returning line item instead of the way it does today. We will not change any payment methodology, just the view of the remit.

Please send EAPG questions to EAPG_QUESTIONS@bcbsal.org.

(PowerPoint presentation continuing)

AUDIENCE: Will the front-end edits for the revenue code be available by 9/1?

MS. MILLER: I'm almost positive. Because from my understanding, they were really just trying to get everything edited. It's not even written, but they're trying to get everything through the draft mode and spell check, all that kind of stuff. So it should be, but I'll double check.

AUDIENCE: Can we back up to the bilateral 50 modifier? I'm not quite understanding the direction for that. So are you saying that we would bill the two lines?

MS. MILLER: Yes.

AUDIENCE: One with quality of 1 with no modifier and one with quality of 1 with a modifier?

MS. MILLER: Yes.

AUDIENCE: That seems a little odd to me.

MS. MILLER: That's how we've always processed, especially on the 1500s.

AUDIENCE: I know, but not on a UB billing.

MS. MILLER: Yes. We didn't recognize it on the UB billing before. We didn't recognize any modifiers except on the Blue Advantage side. So today, for any of our 1500 claims that are bilateral, you have to file two lines. From my understanding, it's going to be the same way.

AUDIENCE: Okay. So you're saying on a UB we'll have to do it this way. I don't think I bill any bilaterals on a 1500 claim today at UAB. So this is very different for UB billing, I think. I don't know about everybody else. I'm not sure how we're going to provide that. That's not how our charges flow to the bill. So I see that as a bit of a problem.

I guess my question is are you wanting us to do like Medicaid does? They don't recognize the modifier 50. Instead, they make us use two lines from the left and the right. So is that what you're really wanting us to do on our bilateral procedures is bill it two lines and use a left and a right modifier?

MS. MILLER: No. They wanted the 50.

AUDIENCE: You're asking can you do two modifiers, the left and right? That's not what they're saying.

AUDIENCE: Oh, okay. A left and a right and a 50. So two lines, one with LT, one with RT, and a 50. Okay. Well, then we need to change our way to bill I guess is what you're saying? Because I think some of us are not billing as you're stating.

MS. MILLER: That's how we've always had it.

AUDIENCE: On 1500.

MS. MILLER: It is. It is.

AUDIENCE: But we're talking UB billers.

MS. MILLER: I understand. But that's still what they're expecting. We're talking about the modifier 50 under the EAPG payment modifier slide.

(PowerPoint presentation continuing)

AUDIENCE: Two quick questions. The inpatient-only list, is this the same as CMS's inpatient-only list?

MS. MILLER: It is not the same.

AUDIENCE: All right. Currently on our procedure list, there are asterisks that reflect procedures that can be out or in.

MS. MILLER: That's removed.

AUDIENCE: It's been removed?

MS. MILLER: Yes.

AUDIENCE: Okay. So on that list, they're inpatient?

MS. MILLER: Correct.

AUDIENCE: Okay.

MS. MILLER: Because we wanted to make sure that if they're on the inpatient-only list that we need for EAPGs, we're not going to make it to where there's no way you can't give reimbursement for that. So that's why they made the choice to go back and add it to the length of stay list. And then if they have the asterisk, remove it, because, well, you can't get reimbursement for an outpatient. We're telling you, you have to file it as inpatient. So we had to make sure that that was covered on both sides.

AUDIENCE: Okay. And you're saying that some procedures that were not on the list, say like a hemorrhoidectomy that was outpatient, would be moved to this list now or we just wouldn't get reimbursed for it?

MS. MILLER: No. It's being moved to the list. We took the master list. Because everybody received a list specific to their facility.

AUDIENCE: Okay.

MS. MILLER: So like I said, when I started reviewing those, a lot of them already had an assigned number of days for the length of stay. They were just being filed as outpatient. So it really was just a handful that there was an issue with.

AUDIENCE: Okay.

MS. MILLER: So your list may be different than UAB's list. So we took the master.

AUDIENCE: Okay.

MS. MILLER: Any other questions?

(No response)

MS. MILLER: And that was on the inpatient-only list for EAPGs.

(PowerPoint presentation continuing)

AUDIENCE: First of all, did I understand you correctly when you said that the list is facility-specific?

MS. MILLER: When we sent the packages to the hospitals, 3M has a lot of propriety information that they would not allow us to give out specific lists. We could give hospital-specific lists. So we couldn't give you the entire inpatient-only list, but we could give you the inpatient procedures that you were filing as outpatient at your facility that are no longer allowed and have to be filed as inpatient.

AUDIENCE: So if we had a procedure that we filed as an outpatient after this goes into effect, how do we know that it was supposed to be an inpatient?

MS. MILLER: Well, your claim will reject saying that it's inpatient-only, but you can also check your length of stay list.

AUDIENCE: Okay.

MS. MILLER: And if you do purchase the 3M software, you get access to all of the proprietary information. So you would get a master list, and it wouldn't be specific to your facility.

AUDIENCE: Okay. Thank you. I just wanted to make sure that I understood you. The only limitation is because of proprietary issues and not contractual from facility to facility?

MS. MILLER: That's correct.

AUDIENCE: Okay.

MS. MILLER: So that's why it's very important for everybody to take advantage of the six months of the free definitions manual. Because otherwise, if you don't purchase the software, then once that six months goes away, you don't get access to the definitions manual anymore. And again, that has where all the logic is, as well.

AUDIENCE: If this is going to be part of the Blue Cross policy, the inpatient-only, I don't understand why you wouldn't publish that. I mean, I realize that there's things that are proprietary to 3M, but even CMS publishes their inpatient-only lists even though the grouper is proprietary to 3M if you purchase their product through them. Since that's going to be a part of your policy, I don't understand why that wouldn't just be out, published by Blue Cross, available for all the providers to review.

MS. MILLER: Because if it's proprietary, then we're held to the contract that we have with 3M and we cannot publish that. But I mean, we have tried to make sure that you're aware of the claims that you've been filing that are now on the inpatient-only list, and we moved everything over to the length of stay list, so you shouldn't have an issue with reimbursement.

Any other questions?

(No response)

(PowerPoint presentation continuing)

AUDIENCE: I work on the acute side with the case management department. And what we were noticing is on procedures that were not typically preauthorized, so gastric bypasses specifically, is that if we had not loaded the preauthorization into JIVA, we were getting denials. We were specifically told that that was not going to happen. So we have had to go back and actually provide some education

to our Blue Cross people, frontline people, that are reviewing our claims. And I just wanted to make sure that that was known, that we were still getting some of those denials even though, again, we've been told that that should not exist.

MS. MILLER: Have you touched base with your provider representative?

AUDIENCE: We have. And she's well aware. And she's actually educated the Blue Cross as well. But every now and then we're still getting some to come through and we go back and take it back to her. But I just want to make sure, because I'm sure we're not the only facility having this issue, that people are aware of that.

MS. MILLER: Okay. Thank you. Is anybody else having the same issue?

AUDIENCE: I am.

MS. MILLER: You are? Are they the same type of surgeries? Is it always the possibly not covered list or is it something that could be cosmetic? Were predeterminations done?

AUDIENCE: Yes.

MS. MILLER: And it was uploaded into JIVA?

AUDIENCE: In our situation, a predetermination was provided to the physician's office, and it was not uploaded into JIVA because it originally was not available in the medical records. So we were receiving denials even though there had been a predetermination. It was available at Blue Cross, but we had not put that into the JIVA system. And we were told again that that should process smoothly. So we had to resubmit those claims, and they did process through the second time. But, again, initially they were denied.

MS. MILLER: I know there are two different ways on those possibly noncovered on how they're supposed to be entered into JIVA. So that certainly may not be what your issue is, but I wanted to make sure that everybody was aware there are two different ways that you're supposed to enter those possibly noncovereds.

AUDIENCE: Our situation was it was approved, it was in JIVA; we just didn't add it to the UB, and it denied.

MS. MILLER: You didn't add it to the UB?

AUDIENCE: Yes. If it was approved, it was loaded in JIVA, but it wasn't in the prior authorization block on the UB. So it denied for no log.

MS. MILLER: Did the code match the same code that the physician filed? Because I know that's been an issue at times as well.

AUDIENCE: All we did is rebilled the claim as a 117, I believe, with the authorization number in there. And it's happened twice, and both of them have paid.

MS. MILLER: Okay. We'd have to probably take a look at some of those. But I have seen where the physician's office authorizes one code, but it's not the same exact code that's filed. And that's not always going to match up, and so it may reject until someone goes out and manually looks at it. But that's because the codes aren't matching.

(PowerPoint presentation continuing)

AUDIENCE: Regarding the patients that don't have PCPs, if they come to the facility ED, because we have a group of patients that refuse to follow up with PCPs and continue to use the ED then are we able to make that patient financially liable?

MS. MILLER: Yes.

AUDIENCE: Okay. Presentation great.

And we have a lot of physicians that really liked the POF ASCs. So have they been instructed that that's going away and the patient's out-of-pocket may be different for the procedures that are going from outpatient to in?

MS. MILLER: I'm not sure if they've been notified at this point. I know that MGMA, the committee came in-house last week, and they did get a presentation on EAPGs. So I know it's at least gotten out through MGMA. But as far as reaching out to specific provider offices to let them know, no.

AUDIENCE: All right. Thank you.

MS. WILLIAMS: And just one more note on the new plans that we've rolled out, when we rolled out those plans, we did not anticipate the volume of people to select the plans. We expected like 10,000. We had over 50,000 select it. So while right now you're looking at two prefixes, we encourage you not to go by prefix at all, the BEG or any of those. You need to be specifically looking at the benefits because they're having to add more as we go along, as more people are selecting this product.

MR. ASHMORE: I want to thank Kathryn and Amber from Blue Cross for coming today. Thank you.

MS. MILLER: Thank you.