BLUE CROSS MINUTES
July 15, 2013 RIC/RAC Meeting

BCBS REPRESENTATIVES PRESENT:
Ms. Jennifer Nelson
Ms. Ginna White
Mr. Chris Dobbs

FACILITATORS PRESENT:
Mr. Ingram Haley
Ms. Karen Northcutt

MR. HALEY: We've got with us Jennifer Nelson, Ginna White, and Chris Dobbs with Blue Cross. And we'll lead off with questions; and then they have a brief presentation they're going to do afterwards.

1. **Follow up to question #1 from the March 11, 2013 RIC/RAC meeting. What is the timeframe allowed for Blue Cross to process an appeal of a Connolly denial? Will Blue Cross delay recoupment until appeal is resolved?**

    - The appeal process can take up to 60 days to complete. The 60 day time frame includes any reprocessing of claims necessary based on the appeal decision. It is our current practice to allow the facility 30 days to appeal an audit finding communicated to the facility by Connolly before making any claims adjustments. If the appeal is not received within 30 days from the date the facility is notified of the audit finding or if the facility agrees with the audit finding we will move forward with the claim adjustment.

2. **Follow up to question #3 from the March 11, 2013 RIC/RAC meeting. Can Blue Cross request Connolly not require providers to send itemized bill with medical records since neither Connolly Medicare nor Cahaba require this?**

    - We have discussed with Connolly and we will work to implement a change that will no longer require the itemized bill unless the claim received outlier payment. We will continue to require the itemized bill for any claim we audit that received outlier payment.

3. **Follow up to question #8 from the March 11, 2013 RIC/RAC meeting for Blue Advantage. What is the formal process for <u>contracted</u> providers to resolve payment disputes?**

    - From our last meeting our understanding is this issue is around the CURP review process. When an in-network Blue Advantage facility is involved and an inpatient stay has been denied, the facility does not have an appeal right per CMS guidelines. There is also no need for the member to appeal because they are held harmless. MAXIMUS Federal Services the IRE (independent review entity)

contracted by CMS for our area told BCBS of Alabama previously to stop sending this type of appeal because the member was held harmless. In June, our health management area sent this type of appeal to MAXIMUS and it was dismissed with the statement the member does not owe any money, so therefore nothing to appeal. The reason the member is held harmless is due to the Blue Advantage contract. Keep in mind, when the member's clinical status does not meet inpatient criteria, it would be best for the facilities to ask the physician to change the order.

Discussion at Meeting:

SPEAKER: If we're doing it in conjunction with CMS, like if it was a Medicare patient, that you do make contact with the provider or of the clinician that's caring for that patient before you make the decision to change their status, is Blue Advantage going to do that and offer that service?

MS. NELSON: I can find out for you. I will put that down.

SPEAKER: So basically, the formal process for contracted providers to resolve payment disputes would be to go back to their contract, which would mean arbitration is the only option?

MS. NELSON: Well, based on the CMS guidelines, there's not an appeal process on the CURP review. If you want to forward me some examples of patients then I can talk with the CURP area about it and get more feedback for you.

SPEAKER: So you're saying, just to make sure I'm clear, that when the clinical status doesn't meet inpatient criteria, we should get with the physician to change the order?

MS. NELSON: Right.

SPEAKER: Is that after the fact?

MS. NELSON: To me, I think the patient would still be in the hospital. So you're putting them into the portal and they're not meeting any, so at that point you want to contact that physician and see if you could change the order. So the patient would be there at that time.

SPEAKER: Okay. So what if the patient is not?

MS. NELSON: If the patient is already gone, I think that's a whole other scenario.

SPEAKER: That's something that we deal with frequently. Once Blue Advantage gets it, because you still have to refer it, if it doesn't meet in CURP, you're going to have to go ahead and send it in. And what we see happening is we'll get a determination after the patient is already gone.

MS. NELSON: Okay.

SPEAKER: So the other thing is that the physician deemed the patient inpatient and felt like it was medically necessary. So I think from our standpoint, even though Blue Advantage has decided the patient only meets observation, where do the appeals rights come in if that's a physician decision?

MS. NELSON: It still goes back to them meeting the criteria. I mean, I don't know what to tell you on that.

SPEAKER: If the patient is in-house, they're supposed to allow an immediate appeal. For all the other Advantage plans anyway, you can do an immediate appeal if they do a denial, the patient is still in-house. The doc is supposed to be able to do a peer-to-peer review.

MS. NELSON: Okay. Well, let's keep this on the agenda and let me take it back to the CURP area and get more feedback for you on that.

4. A. Please provide education on 99495 and 99496 codes.

B. We would like guidance on billing the new Transitional Care Management codes (99495 and 99496) for hospitals. The APC rate has been assigned but we would like guidance on what services should be provided to bill for TCM by the facility. Specific questions: 1) Will the physician fee be reduced if the hospital bills? 2) What services is the hospital receiving payment for? 3) Must the physician face to face portion occur in a hospital based department for the facility to bill TCM? 4) What services is the facility required to provide in order to bill TCM?

- For regular business these codes are non-covered. For Blue Advantage we follow CMS guidelines. See the attachments from CMS. A frequently asked questions document published in March 2013, March 28, 2013, CMS Medicare FFS Provider e-News, May 2, 2013, CMS Medicare FFS Provider e-News, and CY 2013 Physician Fee Schedule final rule published on November 16, 2012 section 68978 – 68994. In the CY 2013 Physician Fee Schedule final rule, CMS recognized two new CPT codes (99495 and 99496) to report physician or qualifying non-physician practitioner Transitional Care Management (TCM) services for a patient following a discharge from a hospital, Skilled Nursing Facility (SNF) or Community Mental Health Center (CMHC) stay, outpatient observation, or partial hospitalization. On March 25, CMS posted a list of Frequently Asked Questions (FAQs) for billing Medicare for TCM Services. The FAQs indicate that CPT codes 99495 and 99496 should be used to bill these services by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Although TCM is a covered service for RHCs and FQHCs, the Fiscal Intermediary Shared System (FISS) currently prohibits these services from receiving the all-inclusive payment rate based on the CPT code. Until system changes can be implemented in FISS, RHCs and FQHCs should bill using the line item date of service that reflects the date of the required face to face component for TCM and should follow the billing instructions outlined below to ensure there is not a delay in their Medicare payments:

    - RHCs should submit claims to their Medicare Administrative Contractor (MAC) with a service line containing revenue code 052X and no CPT code.

- FQHCs should submit claims to their MAC with a service line containing revenue code 052X and a valid evaluation and management (E&M) code. An additional service line should be submitted with revenue code 052X and CPT 99495 or 99496. RHCs and FQHCs providers should follow the above billing guideline until further notice is given. Please contact your MAC should you have additional questions.

5. **Blue Cross has indicated in previous RIC meetings that they do not cover facility clinic visits (CPT codes 99201-99205; 99211-99215) billed with revenue code 510. Is it appropriate to bill these CPT codes under revenue code 761?**

    - If this is for clinic charges then it would be inappropriate to bill under revenue code 761. We do audit for clinic charges being billed inappropriately to us.

Discussion at Meeting:

SPEAKER: That is not true. You can bill under 761. Can Chris Dobbs address that?

MR. DOBBS: I don't have any notes here.

SPEAKER: Because our hospital went through that.

MS. NELSON: What type of services are you billing for?

SPEAKER: It was clinic services in the wound care.

MS. NELSON: Now, wound care you can. Wound care is treated differently.

SPEAKER: Okay.

MS. NELSON: Yeah. Wound care is a little bit different. And that is an exception, so he told you correctly.

SPEAKER: Okay.

6. **A. If a patient is an outpatient and/or observation but is in the hospital and has some rehab service (i.e. physical therapy), in order for the rehab service to be covered, we need a rehab diagnosis code. Can we pick up the code from the (physical) therapist's documentation? Does a treating physician have to countersign the therapist's documentation in order for us to pick up the code?**

    B. In the outpatient setting (OP rehab), can we use the rehab diagnosis/code documented by the therapist without a physician's signature?

C. In the outpatient setting (OP rehab), can we code from the cert and/or therapist's evaluation prior to the MD signing the document?

- Your facility's certified coder should be able to answer these questions. Remember to follow correct coding guidelines.

(Presentation given)

MR. HALEY: Thank you for coming and for your presentation.