

2020 Blue's Tour

August 2020



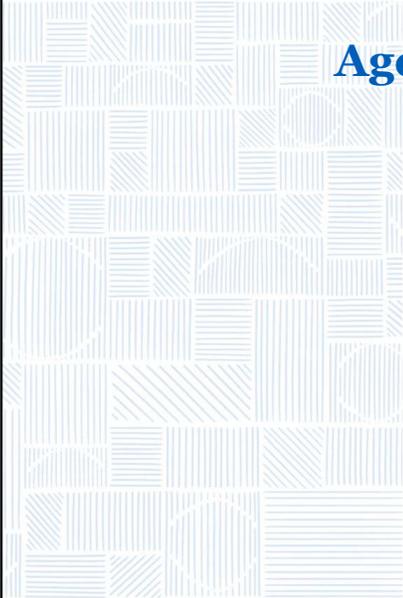
We would like to Welcome you on behalf of Blue Cross and Blue Shield of Kansas to the 2020 Blue's Tour! We are glad you could all join us virtually today! I am Jessica Moore, Education and Communication Coordinator for Institutional Relations. Joining me today from BCBSKS is Cindy Garrison, Provider Consultant for the Northern half of Kansas. Sally Stevens, Provider Consultant for the Southern half of Kansas and Janel Clark, EDI Account Representative.

Before we begin, I would like to just go over some housekeeping items. Please mute your phone/audio devices. If you have a question, please feel free to unmute yourself and ask your question. You can also use the "chat" feature and asked questions there. We will try to monitor the chat questions as we go!

I am going to do a role call for each participant. When you hear your name, please let me know if you are present and if anyone is joining you.

Thank you for allowing us to record all participants.

Let's get started!



Agenda

- » Electronic Data Interchange (EDI) Updates
- » Policy and Procedure Changes for 2021
- » Quality Based Reimbursement Program (QBRP) Changes for 2021
- » Billing Updates
- » Exclusive Provider Organization (EPO) Network Addition
- » Medicare Advantage
- » Top Denials
- » IV Hemophilia Drugs
- » COVID-19 Update

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On the Agenda for today,

First up, we have Janel Clark presenting EDI Updates

Then, Sally Stevens will take over to cover Policy and Procedure Changes for 2021, QBRP Changes for 2021, Billing updates and EPO Network Addition

We will follow with Cindy Garrison who will cover Medicare Advantage and Top Denials

I will finish the presentation off with IV Hemophilia Drugs and a COVID-19 update.

At the end we will be available for open questions. Does anyone have any questions before we begin?

We will switch presenters at this time to Janel Clark.



EDI Updates

Please contact Janel Clark at janel.clark@bcbsks.com for information regarding EDI Updates.



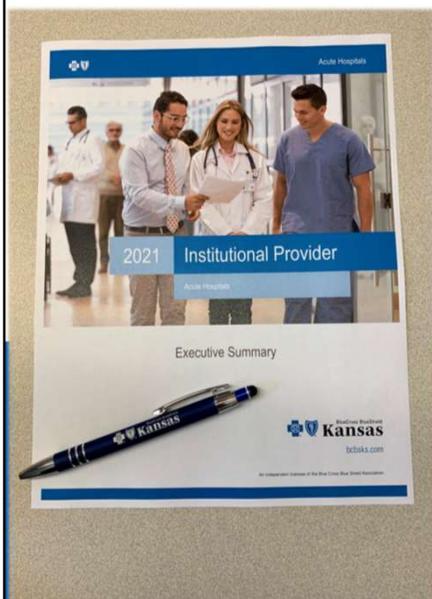
Policy and Procedure Changes for 2021

Contract Mailing

- All documents sent via secure email for 2021
- Documents were sent July 23rd, 24th and July 27th to CEO/Administrator and CFO

Notable 2021 Contract Changes

- Inpatient Incentive
- Interim Billing
- Mid-year Maximum Allowable Payments (MAPs)



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Contract Mailing

- BCBSKS 2021 contract documents were sent to facility CEO/Administrators and CFO's via secure email on July 23rd, 24th and 27th. This year BCBSKS sent all contract documents via email to include the Executive Summary, Policies & Procedures, Payment Attachment, QBRP and MAPs. Please reach out to your administration to obtain copies of any of these documents. The secure email was sent by Veronica Power, Administrative Assistant with BCBSKS. If your CEO/CFO cannot locate the secure email, please check with your IT as the email may have gotten caught in your facility IT security.

Notable 2021 Contract Changes-

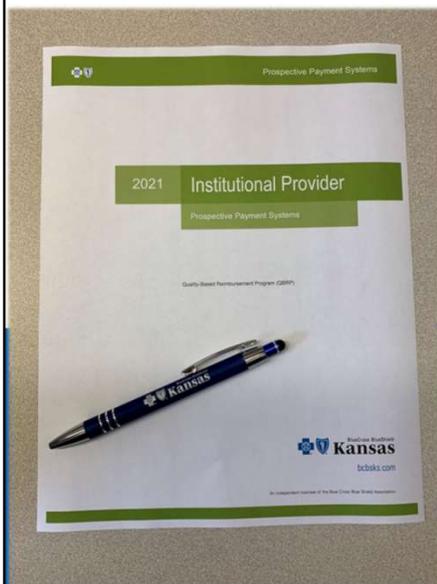
1. For Hospital earning IP incentive payments - The current incentive payment rates in effect for 2020 will remain in place for all of 2021. Please remember, IP incentive payment is different than your QBRP incentive. For questions on IP incentive, please contact either Cindy or myself.
2. For inpatient stays that exceed 30[60] days, interim billings may be submitted 30 [60]days after admission and at 30[60] day intervals thereafter providing proper precertification notices were given as specified in Section 6 of the Policies and Procedures. Interim payments will be estimated. Final

adjudication will be based on the appropriate MSDRG for the entire admission.

3. As new drugs, drug therapies and gene therapies are created, BCBSKS may establish reimbursement rates and/or MAP's mid-year. When this occurs, BCBSKS will notify Contracting Providers via newsletter and when HCPCS codes are created, the reimbursement rates will be reflected in the MAP listing published at least annually.



QBRP Changes for 2021



HL7 Measures All Hospitals

- All 5 HL7 V2 feeds or
- CCD Bundle HL7 V2/V3

Critical Access Hospitals (CAH)

- Removed Overall Sepsis Mortality Rate
- Added Emergency Department Transfer Communication (EDTC)

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HL7 Measures All Hospitals-

1. Although most QBRP measures are the same this year, there are some changes to the Clinical Data Submission measures. For 2021, each provider must have HL7 real-time connectivity to qualify. Providers may earn either the individual HL7 V2 incentive when submitting all five HL7 V2 feeds or the CCD Bundle HL7 V3 incentive but not both when submitting clinical data either to the State approved HIO (KHIN) or the BCBSKS/Verinovum Clinical Data Repository.

- There is no incentive for individual feeds.
- CCD must be HL7 real time. Please check with your vendor regarding real-time CCD feeds to KHIN

CAH Hospitals-

QM15: Emergency Department Transfer Communication (EDTC)

Numerator: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all the following relevant elements were documented and communicated to the receiving hospital in a timely manner.

1. Home Medications
2. Allergies and/or Reactions
3. Medications Administered in ED
4. ED Provider Notes
5. Mental Status/Orientation Assessment
6. Reason for Transfer and/or Plan of Care
7. Tests and/or Procedure Performed
8. Tests and/or Procedures Results

Denominator: Transferred from and ED to another healthcare facility

The incentive will be earned if EDTC rate is greater than or equal to 74% during the reporting period.



Billing Updates

Revenue Code 0510

- Physician specialty not available in the community
- Hospital in a rural area
- Reimbursement based on MAP for Rev Code 0510

Request for Submission of a Split Bill

- Coverage terminated during inpatient stay
- Coverage crosses benefit year
- Newborn claims > 5 inpatient days
 - Baby not added to the policy

Claims Involving Auto Insurance Carrier

- When to file a claim to BCBSKS
 - Same time as filing to Auto
- What does BCBSKS need to process the claim
 - Exhaust Letter
 - PIP itemization

Claim Submission Reminders

- Accident Claims
- National Drug Code (NDC)

Revenue Code 0510-

BCBSKS requires revenue code 0510 to be billed when hospitals are scheduling patients and providing medical services for clinic visits for physicians whose specialty is not available in the rural community. 0510 cannot be billed when the hospital is not in a rural community. A Facility cannot bill a Revenue Code 0510 when the provider type is Primary Care (i.e. Family Practice, Internal Medicine, Pediatrician, or General Practice.)

Providers should not use 0510 for services that do not meet the above definition. If other medical services are provided after the physician assessment, they should be billed using the appropriate revenue code (i.e. 0761) with the CPT code that describes the service. In order to charge for this service, there must be documentation in the medical record to support the visit.

BCBSKS provides billing guide in the Institutional Provider Manual to aid facilities when determining if billing for Revenue Code 0510 for the use of a clinic room is appropriate.

The clinic MAP is based on revenue code 0510 regardless of the CPT code billed.

Requests for Submission of a Split Bill

BCBSKS requests split bills when coverage is terminated during an IP stay, when coverage crosses a benefit year or when a newborn stay is longer than 5 days and is not added to the policy. Claim coding for the entire stay is based on the date of admission. When receiving a request for a split claim, hospitals can either split the claim per the request and submit to BCBSKS as NEW CLAIMS or Submit a claim for the entire stay with itemization that includes Revenue Codes, dates and charges

Claims Involving Auto Insurance Carrier

When submitting claims to BCBSKS that involve an auto insurance carrier, a complete itemization of ALL payments made by the auto insurance must be submitted to BCBSKS before we can process any related claims. A statement from the auto insurance indicating that the maximum has been met showing the total amount of payment made on claims referred to as an "exhaust letter" is not sufficient. Providers may obtain itemization either from the Auto Carrier or the member.

BCBSKS encourages providers to file a claim directly to us at the same time you file to the auto carrier. This will help reduce the risk of the claim being denied for timely filing in the event the auto carrier processes the claim past our timely filing limitation.

Claim Submission Reminders

- Accident Claims
- National Drug Code (NDC)



EPO Network Addition

EPO Network Addition

As of July 1, 2020- Children's Mercy Hospital and Clinics have been added to the EPO network.



Medicare Advantage



Altering Prefix for Eligibility & Benefit Search



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[ELIGIBILITY & BENEFITS](#)

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[AUTHORIZATIONS](#)

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Eligibility & Benefits

Enter the Member ID (beginning with K as it appears on the member's ID card + "00" - example K1234567800)

Note - please include alpha prefix M3A on all claim submissions

Eligibility [Claims](#) [Authorizations](#)

First Name:	Member ID	Date of Birth:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name:		Group:
<input type="text"/>		<input type="text"/>



Submission of Rate Letters





Payment and Remittance Advices



Payment and RA are delivered on Thursday.

You can check claim status. We are still working on having the RA's available for viewing on the website.



Claim Status Update



Known issue:

Providers are receiving an EOP with denial code 852 and the line description is missing. You can call customer service for assistance.



Contact Information

Provider Services and Requests for Organization Determinations			
	Phone	Fax	Hours of Operation
Provider Services	800-240-0577	800-976-2794	8 a.m. – 6 p.m. Monday-Friday
Prior Authorization			
	Phone	Fax/Web Address	Hours of Operation
Prior Authorization Program	800-325-6201	877-218-9089	8 a.m. – 6 p.m. Monday-Friday
New Directions Behavioral Health	877-589-1635	https://webpass.ndbh.com/	
Utilization Management and Care Transition			
	Phone	Fax	Hours of Operation
Utilization Management/ Care Transition	800-325-6201	877-218-9089	8 a.m. – 6 p.m. Monday-Friday
After Hours	800-331-0192	877-218-9089	6 p.m. – 8 a.m. Monday-Friday; 24 hours Saturday-Sunday



BCBSKS Medicare Advantage Provider Page



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Individual and Family Plans

Medicare Plans

Employers with 9 or fewer employees

Employers with 10 to 50 employees

Employers with 51+ employees

Cancer (Secure 300)

Dental

Hospital Indemnity (S-HIP)

Life and Disability

Travel Health Insurance

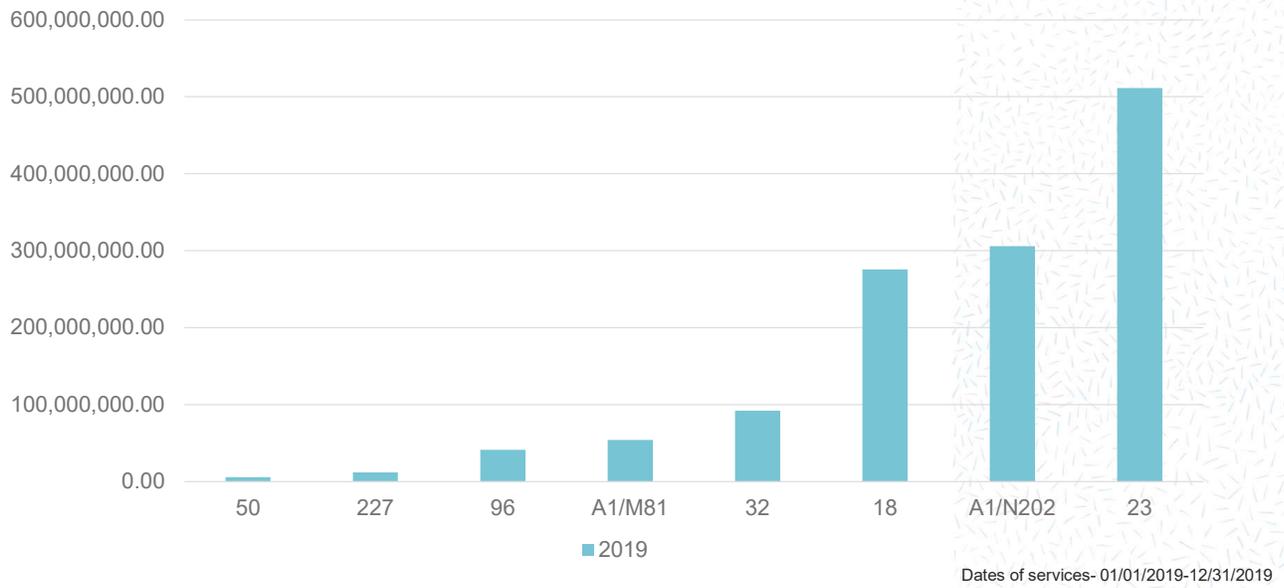


More than health insurance

Our insurance solutions can help you begin your journey toward wellness.



Top Denials- Claims

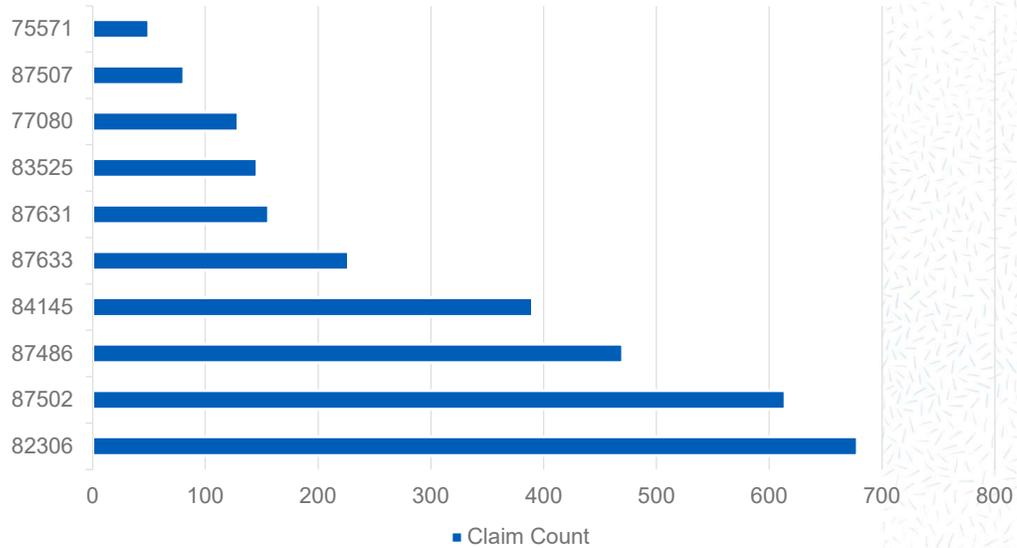


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Dates of services-
01/01/2019-12/31/2019



Top Denials- CPT



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Dates of service- 01/01/20-06/30/20

DOS From 01/01/20 - 06/30/20

Notes 82303, 87502, 87507, 87486, 87631, 87633, 77080, and 75571 all have medical policies

84145 has an internal guide

83525 has an internal guide



IV Hemophilia Drugs

IV Hemophilia Drugs

Effective January 1, 2021, beginning on group renewal date, all BCBSKS members with a pharmacy drug benefit will have to obtain IV hemophilia drugs through a pharmacy. Claims for IV hemophilia drug J-Codes will deny when not submitted by a pharmacy.

Administration of the drug will still be allowed to be billed by the facility.

A list of affected J-Codes is available on our website. Please know, this listing is not final and changes can occur.

https://www.bcbsks.com/CustomerService/Providers/Publications/institutional/newsletters/2019/2019-07-22_results-rx-benefit-iv-hemophilia-drugs.shtml

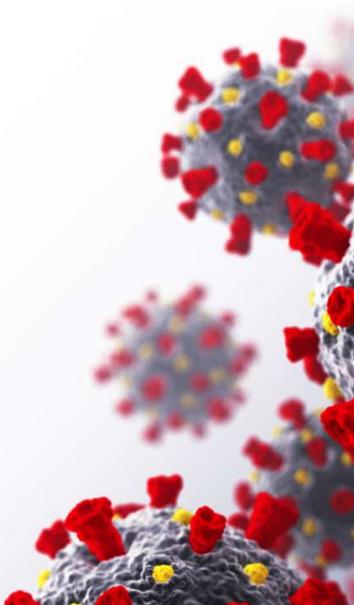
BCBSKS members who have the ResultsRx drug benefit were moved to this policy last year.

Services provided in the Emergency Room for emergency treatment will still be considered under the member's medical benefit.



COVID-19 Update

- Precertification Extension
- Telemedicine Extension
- Revenue Code 0780
- Respiratory/ Flu Panels



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Precertification Extension (June 25th Newsletter)-

BCBSKS will continue to waive the inpatient pre-certification and continued stay review requirement for COVID-19 admissions through December 31, 2020

Telemedicine Extension-

- The expansion of telehealth and virtual services that were effective March 16, 2020 will continue to be allowed through December 31, 2020. They will continue to be paid at parity to in-person services. The expansion of telehealth and virtual services includes provider types, coverage for e-Visits and virtual services provided by facilities. Members will be responsible for their cost-share (co-pay, deductible) for telehealth and virtual services provided on or after July 1, 2020, according to the terms of the members' contracts. The only exception to cost-share is for COVID-19 treatment provided by telehealth.
- Telehealth is defined as real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery, that facilitate the assessment, diagnosis, consultation, treatment, education and care management of a patient's health care.
- Effective 04/16/2020-December 31, 2020
 - Physical/Occupational and Speech-Language Therapy Services

- Lactation Support and Counseling
 - Please note, service dates 04/16/2020-06/30/2020 were covered with no member cost share.
 - Services on 07/01/2020 or after will be subject to applicable cost-share as defined in the member's contract.

Revenue Code 780-

Telemedicine should be billed using Rev. Code 780 w/ an appropriate HCPCS code.

https://www.bcbsks.com/Customerservice/Providers/news/2020/2020-04-14_virtual-services-due-to-covid-19-ub-04-billing.shtml

Respiratory/Flu Panels-

- In accordance with the Families First Coronavirus Response Act signed into law March 18, BCBSKS will be waiving member cost-share (co-pays, deductibles) for the following services associated with the testing of COVID-19:
 - Medically necessary diagnostic tests related to COVID-19.
 - Cost of visit to doctor's office, urgent care, telehealth, and emergency room used for diagnostic testing of COVID-19.
 - Related services (flu tests, respiratory illness tests) provided during urgent care, emergency room, or in-person or telehealth provider visits that result in an order for or administration of a covered diagnostic test for COVID-19.
 - Please note, if a COVID-19 test was not performed within 14 days of a respiratory or flu panel, the claim will be subject to member cost share.



What questions do you all have for us?



"As a member of the community for over 75 years, we've seen the hearts of Kansans shine bright, especially in the most difficult times. Guided by integrity, courage and community, Kansans do the right thing, even when that's the hard thing. And by each doing our part, we'll make it through these challenging times, stronger together. Stay safe. Stay healthy."





Frequently Asked Questions

Q) Are we close on online letters for denials vs. letters on paper?

A) We are still working on this process currently. We will publish this change when it happens via eNews.

Q) Will you bring our facility's personal top CPT denial report on your annual visit?

A) No, BCBSKS will not provide this report.

Q) Is an NDC number required on all claims?

A) No, the NDC number is not required on all claims. When reported, the NDC number must be reported accurately and it must be valid.

Q) What is the best process if I forget to add the GA modifier to the claim, but I do have a physical LPW on file?

A) Please file a corrected claim on paper and attach a copy of the signed LPW.



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