AGENDA

Indiana State Uniform Billing Committee
May 3, 2018 – 2 p.m. EST
Indiana University Health Revenue Cycle Services
Leadership Room 2nd Floor
250 North Shadeland Ave. Indianapolis, IN 46219

Meeting Number: 996 193 457
Meeting Password: This meeting does not require a password.

Audio Connection

32966 (IUH Internal)
317-510-1390 (Indianapolis Local)
844-874-0006 (Toll Free)

Access Code:
996 193 457

1. **Welcome & Introductions**
   Meeting called to order at 2:05PM. Introductions of present members as well as on the phone.

2. **Review of September 21, 2017 meeting minutes**
   Motion to approve as written by Kathy John.
   Seconded by Sherri Hampton.

3. **I-SUBC administrative matters**
   a. Renewal of NUBC subscription – need HFMA renewal for 2018-19 Not due until 07/01/18.
   Jim Miller reports there will be no delay in annual renewal.
   b. www.hfma-indiana.org
   Jim Miller reports there is essentially no new information on the HFMA website.

4. **NUBC update** Tabled until Jim's return
   Jim Miller was able to provide some updates and insight.
   a. **NUBC meetings update**
      i. **August 8-9, 2017 in Baltimore**
   b. **UB-04 Change Implementation Calendar**
   c. **UB-04 Version 9.00 Clarifications/Errata/Updates**
   d. **Upcoming NUBC meeting schedule**
   Jim Miller reports there had not been a whole lot done since last year. April Baltimore meeting minutes will be posted 7/1/18.
   There is news of a new Revenue Code 0206 first announced in 2007 for Intermediate ICU. For Payers that accept paper UB's there is a complete revision to value codes effective 7/1/18. If you are billing any paper UB04's, reach out to Jim Miller for more information at jmiller44@indy.rr.com
   Shannon Bethel-Brown acknowledges there is a new Value Code for 1/1/19 pertaining to 'County'. This will be address in the next business meeting.

5. **Old Business:**

a. **CoreMMIS/Portal update:** Shari Galbreath

Shari Galbreath reminds providers to utilize the Provider Profiles.
States nothing new is going on with the portal.
She announces 'Conduent's' role on or about 7/1/18. This is the broker for enrollments. Providers will still need to be enrolled with Managed Care. All new enrollments will have to go through the enrollment process.
Sherri Hampton inquires about SNF and waiver recipients with liabilities. She indicates ASC is getting over paid, liabilities for patients and providers are dropping out. DXC state they need examples of this situation. It appears it is the Nursing Home level of care that is inaccurate. For Retro Rates, liability is showing $0.00 and it is believe to be a state wide issue. Providers are having to open an appeal on each individual case. Sherri Hampton will get examples to Jenny Atkins.
There was a change of Occurrence Code from 51 to 42 for the Date of Discharge effective 2/13/17 and mass adjustments are going on . It appears DXC is taking the old back and not paying the new rates due to the "old" occurrence code being on claims.
A publication came out for Hospice claims for a mass adjust, BR201816. Providers will be seeing these new rates starting on May 22, 2018.
Jenny Atkins reports there is an issue with the 'tables' for waiver spend down. This have been correct, but here are still working with the state to determine the impact. Providers may send claims through again.

b. **Health Plan Identifiers (HPID) update** Shannon Bethel-Brown

Shannon Bethel-Brown states there is nothing more current that what was in the last minutes. Recognize eventually it will be in place.

c. **Unique Device identifiers (UDI) update** Kathy John

Kathy John reports there is essentially nothing new at this time that impacts providers.

01.16.18 UDI FDA Document.pdf

d. **SSNRI/MBI update:** Shannon Bethel-Brown

HIC's are converting to MBI. This is being pushed out to beneficiaries now. The HIC and MBI will be interchangeable for a window of time until January 2020.

Shannon suggests three (3) ways to ascertain the information:
Ask the patient
Utilize the MAC look up tool
Beginning in October 2018 it will be provided on the Remittance Advice.

There is concern about issues with crossovers and secondary payers. DXC has "by-pass" functionality but it is not known at this time the downstream effect. DXC says they do not make a 'match with ID', just the fact that the recipient has Medicare on file, regardless of submitted or crossover. Indiana anticipates after June of 2018 all beneficiaries will be assigned an MBI it is just possible beneficiaries won't have cards, however the MBI's are showing up in FISS. Shannon Bethel-Brown states if she gets any additional information she will send an email to the group.

e. **Medicare hospital-based ambulance claims** Shannon Bethel-Brown
Members present could not recall what the issue is or what discussion needs to take place. This is tabled until brought forward again.

f. **Modifier to identify all non-340B acquired drugs:** Shannon Bethel-Brown
Shannon Bethel-Brown addresses go-live was 1/1/18. Any JG [modifier] facility reporting status indicator K are impacted. There was a FAQ document posted 4/2/18 explaining the taking back of 22.5% reduction. See New Business 6.e.

g. **MCE issues with data coming from State Medicaid regarding NPI-related denials** Shari Galbreath
Shari Galbreath reports there was an issue of the 'linkage of the rendering physicians in May 2017 pertaining to the 1010 Edit. This stopped claims from going through – DXC set this edit to post and pay until 1/1/18. The Edit was turned back on as this is a requirement that they be linked to 'locations'. There were issues with crossover claims, even in the information was put on the Medicare claim [not required] in Fld 33. This is a coding issues with cross overs from UB to 1500 Claim forms. Shari reports she has not seen any denials but IU Health has 46% denials. Put the group taxonomy in Fld 33. Medicare should be OK. It appears Medicare looks at Fld 32 but Medicaid looks at Fld 33 and when the claims crossover, the information in field 32 on the Medicare claims flips over to field 33 on the Medicaid claim. Providers need to be linked. IHCP provider profiles must have our Medicare information [PTAN] in order for them to actually cross over from Medicare.

h. **Rehab services billing in hospital outpatient vs. clinic/office setting** Group
Group did not feel discussion was warranted.

i. **Indiana Medicaid OPR/taxonomy reporting requirements** Shari Galbreath
OPR's moved over to rendering. Send paper disenrollment for OPR WITH paper re-enrollment for Rendering at the same time, in the same envelope. DXC will disenroll the OPR and enroll the Rendering at the same time. This will mitigate any lapse time. It can be done in the Portal, but there will be a 5-10 day lapse of coverage. PAPER PROCESS IS THE BEST OPTION.
The Taxonomy issue was resolved last fall. All payers, including the MCEs have resolved the rendering taxonomy is not required on a claim.

j. **QMB Postings on Medicare Remittance Advice(s)** Shannon Bethel-Brown
Shannon Bethel-Brown reports cannot charge the patient and causes problems with crossovers. Stopped on 12/8/17. CMS has posted a few change requests:
10433- reinstated QMB off 7/18
CARC 209 with Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer.
RARC N781 No Deductible
N 782 No Co-insurance from patients.
10494 published in March – reprocessed by the MAC's. Gives the MAC's 180 days effective 9/20/18 for mass adjustment but won't cross over. MAC's must report every 2 weeks to CMS. Providers may see RTP's for these.

Janet Mateo reports a mass adjust, and if not, bring it to WPS attention. Patient cannot elect to waive QMB except for non-covered services. Information on WPS portal published 4/19/18. Janet will get clarification on 'explicitly' excluded, meaning excluded NOT not medically necessary.

6. **New Business:**
    a. **FISS update**: Janet Mateo/Specialist Outreach & Education
    MBI – today CMS released an article on the card mailings to newly enrolled in April Beneficiaries. Existing Beneficiaries will begin seeing their cards in June 2018. WPS will be offering a webinar on 5/10/15. In June will be able to use the portal if we have specific patient information. The system will return both the HIC and MBI.
    From 4/1/18 through 12/31/19 Providers can submit either number.

    b. **POE-AG meeting of October 19, 2017 follow-up items** Janet Mateo/Specialist Outreach & Education
    Nothing to report

    c. **POE-AG meeting of March 22, 2018 follow-up items** Janet Mateo/Specialist Outreach & Education
    Janet Mateo states the next meeting is 6/14/18
    She addressed the reprocessing of Therapy claims with KX modifier for Revenue code (s) 42X,43X,and 44X. WPS will reprocess 2018 therapy claims which cannot be automatically reprocessed only if you bring such claims to our attention. See Change Request 10315 for more information.

    d. **Upcoming Indiana Medicaid initiatives** Shari Galbreath
        i. **New APR-DRG Grouper (Version 34)**
        Jenny Atkins states the new Version 35 will be in effect 1/1/19 and the adjudication will be dependent on the Date of Discharge. For an inpatient stay with a discharge of 1/1/19 or after, the APR-DRG payment will be based on version 35.

        ii. **Change in claim filing limitations**
        There will be a change in the Fee For Service filing limit from 365 days to 180 days. Crossover(s) will not have a filing limit as they do today.

    e. AHA 340b lawsuit Shannon Bethel-Brown
    Shannon Bethel-Brown reports the AHA initiated a law suit at the end of last year. Oral arguments were heard 5/4/18. We have information for providers giving appeals of the underpayment for reasons determined. By filing appeals we are showing we don't approved. Recommendation is to do 1st level appeal. Providers are encouraged to get with your regulatory or compliance department to take a stand. It is reported all major players are contesting and is now in Federal Court. The next step is the Supreme Court. Shannon encourages providers to utilize their tech savvy staff to create a template that can auto populate each letter.

7. Open Discussion
    a. DXC 2018 Annual Seminar is tentatively set for 10/23, 24, 25/2018.
    b. Second quarter workshops start in June. Watch for publications.

c. There is a transportation call this date.
d. Janet Mateo reports they have enhanced the portal with an updated way to search LCD's. Find also the Self Service denial tool. Portal users can correct denials or rejects in the portal. One may view as many denials as desired. There are action scripts and More Info buttons in Claim Status on the Portal to correct claims.
e. Education: Webinar on MBI on 5/10/18 and a series of MSP teleconferences and other topics. See live events and on demand courses in the Learning Center. The Learning Center is currently undergoing enhancements. You may now register multiple people and multiple events. Emails went out to Learner Center user with incomplete profiles on 3/22/18 indicating if the LC profile is not updated by July 1, 2018 the profile will be deleted from the Learning Center.
   Upcoming changes to Provider Contact Center (PCC) - Effective May 1, 2018 all EFT and Tax Document and MSP calls will be transitioned to the PCC and on June 1, 2018 all Overpayment calls will transition to the PCC - These enhancements will provide additional services in the PCC, allowing providers to access more information in one call instead of having to call multiple lines.
   2018 Direct Date Entry Recertification WPS GHA is conducting annual DDE User Recertification until August 5, 2018. Each month the DDE Recertification letter will be emailed to the Authorized signer based on your facility's PTAN. For more information, access the DDE Recertification page on the WPS GHA Portal.

Next Meeting – St. Vincent/R1
Date: TBD

Adjournment 3:48 PM