

BWC Policy Alert

Application of EOB 776 procedures

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Purpose

This BWC policy alert clarifies a new definition for Explanation of Benefits (EOB) 776. It also explains the level of review required during the billing process when BWC does not specifically allow the International **Classification of Diseases** (ICD-10) code on the bill in the claim, and the managed care organization (MCO) has applied an override EOB authorizing payment.

Issue

The current definition of the 776 EOB is too narrow and does not include all scenarios for billing purposes. In certain circumstances, the MCOs have asked for reconsideration of what might be redundant reviews by a nurse at the time of authorization and at the time of receipt of the bill.

Discussion

Currently, MCOs must use the override EOB 776 for the scenarios described below.

- ▶ Treatment of a non-allowed, but related condition:
 - Any situation in which an ICD-10 code is not allowed in the claim, and the service is for this non-allowed, but related condition.

- ▶ Treatment of an allowed condition that:
 - Is billed with a health status code (V or Z code);
 - Is billed with an ICD-10 code that has a digit expansion;
 - Meets the criteria for presumptive authorization;
 - Is prior authorized and the diagnostic procedure is related.

In any of the circumstances defined above, the system will deny bills with edit 387 unless the MCOs apply the override EOB 776. BWC defines Edit 387 as **the primary billed ICD is not related to any of the codes that are allowed in the claim**. However, the current definition of EOB 776 (**payment is being made for a non-allowed, but related condition**) does not specifically include when treatment relates to the **allowed** condition.

Treatment of non-allowed conditions

Bills submitted with non-allowed diagnosis codes will cause the system to apply edit 387, thereby denying the bill.

To authorize payment in these situations, the MCO would use EOB 776 as an override, apply the *Miller* criteria and document it in the case. As stated in the *Use of EOB 776* policy, when an MCO uses override EOB 776 for the use of the *Miller* application on a bill, an MCO nurse or coder must perform a review of the medical. He or she then enters a claim note addressing the rationale for using EOB 776, citing specific medical documentation used in decision making and providing an analysis of how each of the three prongs of the *Miller* test were satisfied to justify medical payment in the system. You can find examples to reflect an appropriate application of *Miller* in the treatment of non-allowed conditions in the *Use of EOB 776* policy.

Treatment of Allowed Conditions

Bills submitted with non-allowed diagnosis codes will cause the system to apply edit 387, thereby denying the bill. You can find examples to reflect an appropriate application of *Miller* in the treatment of allowed conditions in the *Use of EOB 776 policy*.

- BWC requires providers to bill using an appropriate **V (ICD-9-CM) or Z (ICD-10-CM)** health status code for certain services. However, the ICD-10 codes for services are not claim allowances and result in bill denials. Although MCOs could override and authorize payment, when appropriate, for the use of the V or Z code, the MCOs could only do so by using EOB 776.
- Additionally, prior to initiating systematic updates to recognize ICD-10 codes with **expanded digits** for specificity, use of the more specific ICD-10 code that had not been updated in the claim is also resulting in a denial of the bill. Although MCOs could override and authorize payment, when appropriate, for the digit expansion, the MCOs could only do so by using EOB 776.
- Application of EOB 776 may be appropriate for services rendered when an injured worker has an allowed diagnosis and he or she has symptoms indicating further **diagnostic studies** are necessary to determine if a more extensive work-related injury than previously identified has occurred.
- Finally, MCOs may use EOB 776 to override edit 387 when the provider is using **presumptive authorization** to provide specific services when treating soft tissue and musculoskeletal injuries that are allowed conditions in the claim. Presumptive authorization must meet the criteria defined in the presumptive authorization policy.

In the circumstances described in this section, **Treatment of Allowed Conditions**, BWC has developed an informational EOB to append when applying **EOB 776 for services related to the allowed condition(s) in a claim. BWC defines EOB 779 as payment is being made for treatment related to the allowed condition (V or Z code; digit expansion; presumptive auth; diagnostics).**

MCOs have expressed concern over the redundancy of a nurse or coder performing a *Miller* review at the time of authorization of the service and then a second time when receiving the bill for treatment for the situations covered in this section, **Treatment of Allowed Conditions**.

In situations where a prior-authorized treatment or a related service is billed for treatment of an allowed condition or the code is a health status code or digit expansion, so long as a nurse or coder has completed an analysis of *Miller* and has determined that the services are related to an allowed condition and/or has prior authorized the treatment, it is not necessary for a nurse to perform a second review at the time of receipt of the bill. Instead, a coder or a biller can add a note documenting the review of the bill in conjunction with the original *Miller* note, authorize payment and append the informational EOB 779 to the EOB 776.

Conclusion

BWC is expanding the definition of the override EOB 776 to include treatment related to allowed conditions. We will re-word the definition of EOB 776 as described below.

Payment is for:

- ▶ Treatment of a non-allowed, but related condition;
 - Any situation in which an ICD-10 code is not allowed in the claim and the service is for this non-allowed, but related condition.
- ▶ Treatment of an allowed condition that:
 - Is billed with a health status code (V or Z code);
 - Is billed with an ICD-10 code that has a digit expansion;
 - Meets the criteria for presumptive authorization;
 - Is prior authorized and the diagnostic procedure is related.

BWC is adding informational EOB 779; **payment is being made for treatment related to the allowed condition (V or Z code; digit expansion; presumptive auth; diagnostics)** to address the situations noted above when the treatment relates to an allowed condition.

Finally, BWC is altering the note requirement for treatment of allowed conditions when MCOs append EOB 779 to EOB 776.

When the EOB combination of 776 and 779 occurs, BWC is authorizing the review by a coder or biller, instead of a nurse, at the time of the bill receipt in the following situations:

1. Prior authorized services were billed with a valid V code (ICD-9) or Z code (ICD-10). There is clear documentation of an analysis of *Miller* at the time of prior authorization by a nurse or a coder;
2. Prior authorized services were billed with a valid ICD code that is a digit expansion of the code set. There is clear documentation of an analysis of *Miller* at the time of prior authorization by a nurse or a coder;
3. Services billed fall within presumptive authorization guidelines, a C-9 is present for the service and it references a nurse or coder note, documenting the presumptive authorization status of the service;
4. A prior authorized diagnostic test was billed. There is clear documentation of an analysis of *Miller* at the time of prior authorization by a nurse or a coder.

In the above-listed situations, a coder or a biller must, after review, systematically or manually create a note that refers back to the original *Miller* review note, which either a nurse or a coder created. Any systematic action will not replace the biller or coder reviewing the bill and ensuring the prior note is complete.

If services do not fall within the above scenarios, the use of the informational EOB 779 would not apply. In that case, a nurse or coder must complete an EOB 776 utilization review that meets the standards of the current Use of *EOB 776 policy*.

Reference: MCO Policy and Reference Guide Chapter 8, pages 56-62, Application of the *Miller Criteria with EOB 776*