An overview and the impact of the ACA

North Carolina Association of Radiology Business Managers
Myrtle Beach, South Carolina
June 19, 2014
- Welcome and Introductions
- About BCBSNC
- ACA and it’s impact
- BCBSNC diagnostic imaging management program
- Latest news and reminders
- ICD-10
- Resources
- Wrap-up/Questions
About BCBSNC
Our Mission
To improve the health and well-being of our customers and communities.

Our Vision
To be a consumer-focused health solutions company that leads the transformation of the health care system.
The ACA and it’s impact
The basics

- Congress passed the Affordable Care Act (ACA) in March 2010. The law intends to address certain fundamental issues with our current health care system, outlining a plan to:
  1. increase access to health insurance
  2. implement insurance industry reforms
  3. improve health care quality, and
  4. curb rapidly rising health care costs
The major, more transformational aspects of health care reform take (or have taken) effect in 2014.

- The individual mandate to purchase health insurance
- Expansion of the Medicaid program
- Employer Shared Responsibility Excise Tax
- New rules which will change the way insurers operate
- Changes to the way Americans shop for and buy insurance through the creation of “Exchanges”
- Many provisions requiring that certain standard benefits are included at a minimum
- Level of coverage
Educating North Carolinians about the law

www.nchealthreform.com

- BCBSNC was among the nation’s first insurers to explain the meaning of health care reform broadly, launching an educational, stakeholder-specific website just four months after ACA passage.

- The BCBSNC Health Policy Office regularly publishes a series of white papers on ACA-related topics which are particularly relevant to the business, or the public at-large. Each “Spotlight” article contains an issue summary, BCBSNC’s position on the matter, expected impacts on the state of North Carolina specifically and more. The “Spotlight” articles can be found in the Spotlight Archive at www.nchealthreform.com.
2014 ACA products

BlueAdvantage®
(Individual market only)

BlueOptions™
(Employer market only)

BlueSelect™
(Individual & employer market)

BlueValue™
(Individual & employer market)
Blue Advantage offers broad choice of doctors, specialists and hospitals with a deep, broad network

- Large provider network – 91% of doctors and 99% of hospitals in-network\(^1\)
- Fewer prescription drug requirements
- No referrals needed
- Plan pays 100% of preventive services\(^2\)
- Variety of benefit options, including Health Savings Account (HSA) eligible plans

\(^1\) Consortium Health Plans, Inc., MarketQuest Network Compare, April 2013.
\(^2\) Preventive care services as defined by recent federal regulations are covered at no charge to you. For Blue Advantage, Blue Select and Blue Value: Coverage for certain preventive care services (such as routine physical exams, well-baby and well-child care, and immunizations) is limited to in-network benefits only. However, state-mandated preventive services are available out-of-network, for which members will pay deductible and coinsurance, plus charges over the allowed amount. Visit bcbnsnc.com/preventive for more details.
With Blue Select, we’ve tiered benefits and providers in our broad Blue Advantage/Blue Options network to help members make the most of health care spending. We evaluated doctors and specialist physician practices on their quality outcomes, cost efficiency, and accessibility and created two categories.

- **Tier 1** are providers who received our top ratings, and members receive a richer benefit when they choose these providers
- **Tier 2** are providers who still meet our usual standards for being part of the network, and members receive a less rich benefit when they choose these providers

Blue Select offers more prescription drug requirements and a smaller pharmacy network.
Blue Value features a limited network of providers and some of the lowest costs of all our plans.

- A limited network of doctors, hospitals and pharmacies to lower member costs
- More prescription drug requirements to help members save money
- Plan pays 100% of preventive services\(^2\)
- No referrals needed

\(^1\) Blue Value may not be available in all major metropolitan areas. Visit bcbsnc.com for more information.
\(^2\) Preventive care services as defined by recent federal regulations are covered at no charge to you. For Blue Advantage, Blue Select and Blue Value: Coverage for certain preventive care services (such as routine physical exams, well-baby and well-child care, and immunizations) is limited to in-network benefits only. However, state-mandated preventive services are available out-of-network, for which members will pay deductible and coinsurance, plus charges over the allowed amount. Visit bcbsnc.com/preventive for more details.
Variety of distribution points

Individual consumer market

BlueAdvantage®
BlueSelect™
BlueValue™

Authorized Agents of BCBSNC

The Health Insurance Marketplace is an independent entity run by the federal government
### Individual Consumer Portfolio

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<tr>
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<td></td>
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<tr>
<td><strong>Total</strong></td>
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<td>6</td>
<td>11</td>
<td>5</td>
<td>2</td>
</tr>
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</table>

- Same plans on/off Marketplace
- Same price on/off Marketplace (pre-subsidy)
- Blue Advantage & Blue Value have same benefit designs
All new individual market plans sold on and after January 1, 2014 must cover 10 essential health benefits.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including vision care and pediatric dental services*

*If stand-alone dental plans are offered on the Marketplace, then Qualified Health Plans offered through the Marketplace may exclude pediatric dental coverage.
Extended grace period—subsidized members

- Providers are notified when submitted claims are pended due to nonpayment of premium
- Claims in the first month are paid
- Medical claims in the second and third month are pended and members are responsible for 100% of our contracted rate at the pharmacy until the account is brought to current with premium payment
- No reinstatement

* Pharmacy costs are eligible for reimbursement (subject to applicable deductible and copays) once the account is brought to current with premium payment.
ACA wrap-up

- BCBSNC has many plans that meet ACA requirements for individuals and employers
- Plans are subject to a variety of ACA and regulatory requirements, dependent on many different factors
- Benefits can be different from plan to plan
- All products and networks are the same no matter where a patient purchased them (on or off the Marketplace)\(^1\)

\(^1\) Premium Tax Credits (subsidies) and benefit variations that occur due to subsidy eligibility and/or certain other eligibility status, such as American Indian/Alaska Native status, are only available through the Health Insurance Marketplace. All plan designs in a product are rated the same based on age, region and smoking status.
Health care reform questions

- Questions can be directed to: [www.nchealthreform.com](http://www.nchealthreform.com)
Diagnostic imaging management program
The purpose of BCBSNC’s radiology program is to reduce health care costs by ensuring:

- The most appropriate exam is ordered for the diagnosis
- Studies are performed in the proper sequence
- No duplication of tests are performed
- Compliance with BCBSNC corporate medical policies regarding medical necessity
Prior review is required for the non-emergency, outpatient, diagnostic imaging services listed below – when they are performed in a physician’s office, the outpatient department of a hospital, or a freestanding imaging center:

- CT/CTA scans
- MRI/MRA scans
- Nuclear cardiology studies
- PET scans
- Transthoracic Echocardiography (TTE)
- Transesophageal Echocardiography (TEE)
- Stress Echocardiography (SE)
Services not requiring prior review

- Services not included in the program:
  - Low-tech diagnostic services such as X-rays and mammograms
  - Emergency room services, observational stay, hospital inpatient stay
Who’s participating?

- The majority of BCBSNC members are participating in the program.
- Authorization is required when BCBSNC is considered secondary insurance (such as to Medicare primary).
- Other Blue Plans may utilize AIM as their radiology vendor; however, services for BlueCard members from non-North Carolina, Blue Cross and/or Blue Shield Plans are **not** included in the BCBSNC's radiology management program administered through AIM.
- A group ID query is available at bcbsnc.com to assist in determining who is in the program.
Obtaining authorizations

- Ordering providers must obtain an authorization before the service is rendered.

  **Note:** The PCP does not have to order for a specialist. The ordering provider is the provider requesting the exam.

- Servicing providers (radiologists) cannot obtain prior review for exams. However, servicing providers should always verify that an authorization was obtained, prior to scheduling the exam.

- Authorizations are valid for **30 days** from the date of the decision.
What’s prohibited

- As part of the diagnostic imaging management program, BCBSNC prohibits:
  - A servicing location to market or offer to BCBSNC referring providers, their services in obtaining the certification from AIM on behalf of the referring physician.
  - A referring physician to allow the servicing location to contact AIM on their behalf to request the certification for diagnostic imaging management services.
Ordering physicians can obtain and confirm certification by contacting AIM in one of the following ways:

1. By logging on to provider portal through *Blue e<sup>SM</sup>*: seven days a week, 4 a.m. to 1 a.m., eastern time

2. By calling AIM: 1-866-455-8414 (toll free), Monday through Friday, 8 a.m. to 5 p.m. eastern time.

Not registered to use Blue e<sup>SM</sup>?

Register online at [https://providers.bcbsnc.com/providers/login.faces](https://providers.bcbsnc.com/providers/login.faces). BCBSNC provides Blue e<sup>SM</sup> to providers free-of-charge.
Prior review code list

- BCBSNC’s prior review list for diagnostic imaging services is available at bcbsnc.com
- The list is subject to change once per quarter:
  - January
  - April
  - July
  - October
Requests involving multiple examinations of contiguous body parts that are not approved prior to physician review, will be subject to a mandatory peer-to-peer conversation.

If the AIM physician reviewer cannot reach the ordering provider for the mandatory peer-to-peer review, none of the multiple exams requested will be approved.

Coverage of services are subject to the terms and conditions of the member’s health benefit plan and applicable law.
Member involvement

- In-network providers are responsible for obtaining prior review on behalf of the member.
- Member waivers should not be used to avoid the requirement of having to request prior review.
Retrospective requests will not be considered. The exception would be for urgent cases filed within two business days after the date of the service.

“Urgent” (as defined by ERISA):

Occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that in the absence of immediate care the member could reasonably be expected to suffer chronic illness, prolonged impairment, or the need for more hazardous treatment.
- BCBSNC has adopted AIM’s clinical guidelines. Access the guidelines at [http://www.bcbsnc.com/content/services/medical-policy/dim-policies.htm](http://www.bcbsnc.com/content/services/medical-policy/dim-policies.htm)

- BCBSNC experimental/ investigational policies still apply

[http://www.bcbsnc.com/content/services/medical-policy/index.htm](http://www.bcbsnc.com/content/services/medical-policy/index.htm)
- Get answers to your questions about the program by reviewing the “frequently asked questions”.

- Training materials:
  - Program overview
  - Ordering Provider Quick Reference Guide
  - Servicing Provider Quick Reference Guide
  - AIM Provider Portal Quick Reference Guide

https://providers.bcbsnc.com/providers/imaging.faces
Latest news and reminders
New technology platform

- BCBSNC migrating to a new technology platform in an effort to better support industry changes.
- Provides a technology suite for many of our customer interactions.
- Designed to increase the efficiency in membership operations.
- The first customer segment enrolled on the new technology suite will be new, small employer groups consisting of 1 to 50 members.
- All commercial membership is expected to migrate onto the new technology platform by the end of 2016.
April 21, 2014, the requirement for physician supervised physical therapy prior to imaging was removed from the following indications:

- Ligament and tendon injuries
- Epicondylitis
- Persistent lower extremity pain (excluding the knee joint)
- Acute and chronic tendon injuries – foot and ankle

**Chondromalacia patella:** The conservative treatment timeframe criteria was reduced from 12 weeks to 4 weeks.

**Hemarthrosis:** Imaging indication was modified to include instances when arthrocentesis may be contraindicated.
In January of this year, BCBSNC expanded the diagnostic imaging management program for our Medicare Advantage plans (Blue Medicare HMO\textsuperscript{SM} and Blue Medicare PPO\textsuperscript{SM}) to include echocardiography services

- Transthoracic Echocardiography (TTE)
- Transesophageal Echocardiography (TEE)
- Stress Echocardiography (SE)

Pre-exam questions (PEQs) are requested for stress echocardiography. Completing the PEQs for these exams reduces the time it takes to receive the order number.
CT Abdomen and Pelvis Combination

- New CPT codes were created in 2013 to represent the combination service of pelvic and abdominal computed tomography angiography (CTA).

- Use the AIM Tip Sheet when selecting the "Exam Description" in the AIM portal when initiating a request - CTA of the pelvis and abdomen should not be ordered separately.

- If one of the exams is "added-on" to an existing authorization for either a pelvic or abdominal CTA within the 72-hour window after the initial service is requested, the combination codes will also be sent to BCBSNC for claims processing purposes.
BCBSNC is hosting regional conferences in September of this year:
- Charlotte
- Chapel Hill
- Greenville

Focus on ICD-10 readiness

Featured speaker - national industry expert on the topic of ICD-10 compliance.

Medical practice staff with ICD-10 implementation and/or compliance responsibilities are encouraged to attend.

Registration information available at:
Providers have **90** calendar days from the claim adjudication date to submit an Appeal.

- Billing and coding
- Medical necessity

Provider Appeal reviews are completed within **45** calendar days of the receipt of all information for commercial business and **30** days for Medicare Advantage.
HIPAA privacy regulations allow a member to pay the total cost of a medical service or services and request that a provider keep information about that service or services confidential.

In these instances, providers are required to abide by the member’s request and not submit a claim to BCBSNC for the specific service(s) in question.
ICD-9 codes should be assigned to the highest level of specificity using the fourth and fifth digits where applicable.

- ICD-10 codes should be submitted in alignment with the compliance date of October 1, 2015 and assigned to the highest level of specificity applying up to the seventh digit where applicable, and providing the highest degree of accuracy and completeness.

- BCBSNC system edits are in place to ensure a consistent claim review process.
Claim delay letters – when are they sent?

- As required by the North Carolina Prompt Pay law, all payers are required to send notification to providers when there is any delay in the processing of a claim.

- Letters are generated whenever a claim remains open and reaches the certain age(s) in our claims processing system - 30, 60, 90, 120 and 150 days.

- If a claim is still open in our system and has not been determined it is a true duplicate, any duplicate claim submitted will be treated like any other claim waiting to be processed.

Outstanding claims greater than 60 days, and you've not already spoken to one of our provider specialists, call 1-800-214-4844 for assistance.
Claim status messages on Blue e℠

- **Process Date:** The last date a course of action was taken on a claim as it goes through our processing system. This date can change multiple times until the claim is finalized. Providers should not be concerned if the process date changes on a pended claim.

- **Payment Date:** A claim in a pended status will not show a payment date. Once the claim cycle is complete, and a payment or denial is issued, the “Payment Date” will display on the final claim.

- **Amount Paid:** The estimated amount the claim is likely to pay unless changes occur before the payment cycle is completed. The “Amount Paid” can potentially change by the time the claim is finalized, especially for a Federal Employee Program claim.
ICD-10
ICD-10 will change everything

Will you be ready?
ICD-10 facts

- The industry-wide conversion to ICD-10 will occur October 1, 2015. All HIPAA covered entities are required to use ICD-10 codes on all transactions, claims, authorizations, referral requests, verification of benefits and eligibility beginning on this date.

- Payers are not allowed to accept non-compliant ICD-9 codes for dates of service beginning on this date and must reject them in order to be compliant with the mandate.

- Pre-authorizations will be based on the request/transaction date and NOT the service date. If the request/transaction date is prior to 10/1/2015, it will require an ICD-9 code, if after 10/1/2015, it will require an ICD-10 code.
Additional facts

- If your practice is submitting HIPAA 4010 claims to your clearinghouse, you MUST convert to HIPAA 5010 claims prior to October 1, 2015. The clearinghouse WILL NOT BE ABLE to convert ICD-9 codes into ICD-10 codes for use in the HIPAA 5010 claims transaction. ICD-10 is different from ICD-9 in structure, organization, and capabilities; it requires seven (7) characters and cannot be sent in a HIPAA 4010 claims transaction.

- Provider lack of readiness will create major business disruption for BCBSNC with increased inquires, corrected claims and suspended claims.

- Provider noncompliance will increase business disruption for provider and billing staff and will disrupt provider revenue stream.
Provider readiness recommendations

- Educate physicians and coders on the new codes and documentation requirements for ICD-10.
- Check to assure that documentation (in EMR or hard copy record) is specific enough to assign a code using ICD-10.
- Begin steps to transition now. It’s not too early!
- Talk to your vendors and make sure they are ready for ICD-10 implementation on October 1, 2015.
- Reference the CMS website on a regular basis for updates, guides, tools and bulletins.

https://www.comsgov/ICD10
# Impact assessment

<table>
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<tr>
<th>Degree of ICD-10 changes</th>
<th>Provider specialty</th>
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<tbody>
<tr>
<td>High</td>
<td>OB/GYN, Orthopedics, Psychiatry, Gastroenterology</td>
</tr>
<tr>
<td>Medium</td>
<td>Primary Care, Lab, Optometry</td>
</tr>
<tr>
<td>Low</td>
<td>Dental, Convenience Care, School clinic</td>
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Assessment Surveys
- BCBSNC will be assessing all participating facilities throughout NC.
- Providers will be requested to complete a survey that will provide BCBSNC a high level indication of the provider’s readiness to use ICD-10 codes as of 10/1/15.

Collaboration Efforts
- North Carolina Medical Group Managers Association
- North Carolina Hospital Association
- North Carolina Medical Society
- North Carolina Healthcare Information and Communications Alliance
- Area Health Education Center
All electronic or paper-based transactions for services on or after the compliance date, must contain ICD-10 codes or they will be rejected.

Under the Administrative Simplification provision requirements, if providers use ICD-9 codes in transactions for services or discharge dates on or after October 1, 2015, the claim will be rejected as noncompliant, and the transaction will not be processed. Providers may experience disruptions in transactions being processed and receipt of payments if they submit noncompliant transactions.
BCBSNC is taking the necessary steps to ensure that all systems and processes will be compliant by October 1, 2015.

BCBSNC is evaluating the provider testing approach and plans to be ready to begin testing with select providers in 2014.

BCBSNC has identified 20 medical policies that will be impacted by ICD-10 coding changes. These policies have been updated to reflect the new ICD-10 codes in the billing/coding sections of each respective medical policy that is affected.

http://www.bcbsnc.com/content/services/medical-policy/updates/index.htm
## Industry resources

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Provider portal
www.bcbsnc.com/providers

- Highlights of the Provider Portal include:
  - Current news and information
  - Education & learning center
  - eManuals
  - Interactive provider forms
  - Online newsletter
  - Quick access to BlueCard®, Blue Medicare® and Dental Blue® information
  - Blue e® information
www.bcbsnc.com/providers

Provider email registry

Get the Latest News
Join our email registry for the latest news, policy changes, online course offerings and more.

Register Now

Provider Email Registry

Complete the form below to be added to our mailing list and get the latest updates from BCBSNC.

Name:

Company Name:

Email:

- HTML
- Text

Subscribe

Unsubscribe

Submit

This is an opportunity for you to receive real-time BCBSNC news and updates sent directly to you via email – sign-up today using the Register Now link on the Provider home page at www.bcbsnc.com/providers.

Powered by ExactTarget.
Network management

- Dedicated staff to serve as a liaison between you and BCBSNC.
- Staff is available to assist with:
  - Questions regarding BCBSNC contracts, policies, and procedures
  - Changes to your organization including:
    - Opening/closing locations
    - Change in name or ownership
    - Change in Tax ID#, address or phone number
    - Merging with another group practice
Your PSA’s are able to assist with:

- Providing you information on how to obtain your fee schedule
- Making any necessary demographic changes – notice address, billing address and etc.
- Add/Remove providers from your practice

P: (800) 777-1643 8am-4pm
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Thank you!