North Carolina Health Insurance Institute
October 10 – 11, 2013
Overview

- Electronic Solutions
- Operational Updates
- 2013 Updates
- Medicare Advantage Risk Adjustment Initiatives
- HEDIS Changes
- Health Care Reform Updates
- Provider Survey
- ICD – 10
- Tools and Resources
Blue e Changes

November 2013 to February 2014
**Health Eligibility:**

1. **Employer-Funded HRA – Fund Balances**
   - For HRA accounts that are funded by employers, details about the fund are retrieved and posted to the Member Tab.
   - Balance reflects fund amount in account at that moment in time
Incentive Options for State Health Plan members only – Effective 1/1/14

- Incentive programs for PPO (*80/20) and HRA Funded plans
- PCP (Primary Care Physician) election required for incentives to apply
- Copays -$10 PCP/$15 Spec/$50 Hospital (parallel HRA fund contribution)
- New Cost/Quality Network designations for specialists and hospitals
- New SHP ID cards with PCP identification (Note: member can change PCP selection at will and new cards will be issued. Check your patient’s cards to determine if you are elected PCP)
Blue e Health Eligibility: Benefit Detail Tab

- PCP election will not be displayed in *Blue e*. Providers will see:
  - multiple copay options based on
    - POS,
    - Specialty,
    - Service type.
  - The lowest copay amount applies for elected PCPs or tiered 1 places of service.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Network Status</th>
<th>Covered Benefit</th>
<th>Copay</th>
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<tbody>
<tr>
<td>Professional (Physician) Visit - Office</td>
<td>In Network</td>
<td>Primary Care Physician</td>
<td>COPAY: $30.00 per VISITS</td>
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<td>Selected Primary Care</td>
<td>COPAY: $15.00 per VISITS</td>
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<td>Hospital In Network</td>
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Blue e November Changes – cont.

- Remittance Inquiry - new radio buttons – 11/24/13
  Recoupment reports will be available for MedAdvantage and Medicare Supplemental claims EOP from the Remittance Inquiry transaction. See new Blue e user interface below:
Blue e February Changes

+ **Clear Claim Connection (C3) – Home page links change**
  - Current three C3 links will be replaced by one, in February
  - For 60 days prior to that change, a ‘future state’ link will be available
  - All Dates of Service can be inquired on through the one link

+ **Authorization Request and Case Status Upgrade**
  - New look and feel
  - Essentially the same functionality

+ **Pre-service Reviews for IPP members via Blue e**
  - Perform radiological, inpatient, or outpatient preservice reviews for Out of Area (BlueCard) members via Blue e
  - Providers in other states can perform preservice reviews on local (NC) members
Blue e CMS1500 Changes

A copy of the new CMS1500 form can be found in NUCC Manual, published in June 2013

- **Corrected Claim Indication:**
  - Box 22 = Resubmission Code
  - Use ‘7’ for corrected, ‘8’ for voided claims.
  - Claim ID in second field.

- Upper level 24D used for unspecified code, as well as NDC code.

- Taxonomy code can be placed above rendering provider.
EFT - Payment Made Fast and Easy

- Direct Deposit of Claims Payments to your bank account

- All product lines are now available for direct deposit:
  - Federal Employees Program (FEP) **Starting this week!**
  - Commercial / State Health Plan
  - ASO
  - Medicare Supplement
  - Blue Medicare HMO
  - Blue Medicare PPO

- Safer than paper checks which can get lost, stolen, or damaged

- EFT funds are accessible by providers sooner than manual paper checks arriving in the mail.

- Enroll online via *Blue e* or fax in form from www.bcbsnc.com
Patient Care Summary (PCS)

A member level report* available through Blue e that includes:

- Gaps in Evidence Based Care
- Prescription history
- Medical Care history
- Provider Alerts

Requires a special “PCS” Blue e user role, which can be assigned by talking to your practice’s Blue e administrator.

Proper distribution to appropriate personnel (caregivers) is vital.

Providers should use discretion since you’re responsible for distribution of PHI.

For questions about, email the eSolutions HelpDesk at Bluee.helpdesk@bcbsnc.com or call 888-333-8594.
Browser Upgrade Required for Blue e

+ *Blue e* users must be on Internet Explorer (IE) browser version 8 or higher after November 16th.
+ IE 8 users must have the highest Service Pack (SP) and the latest patch
+ For assistance with upgrading your browser, refer to the Resources tab from the *Blue e* Home Page.
+ Get help from your computer support personnel or the eSolutions HelpDesk at 1-888-333-8594.
+ If not upgraded, you may encounter issues accessing *Blue e* after November 16.
Operational Updates
FEP Migration to the Power MHS System

- Federal Employee Program (FEP) claims processing was transitioned to our Power MHS system in May 2013.
  - Provide better service
  - Expedite claims transactions
  - Improves accuracy
  - Better alignment with other BCBSNC lines of business

- The Explanation of Payment (EOP) now has the same familiar look as the EOP for our commercial lines of business
  - clearer descriptions on column headers
  - enhanced remark codes with easy to understand descriptions

- Electronic Funds Transfer (EFT) for FEP is planned for the week of 10/7/13.
When a Medicare claim has crossed over (from Medicare to BCBSNC), providers are to wait 30 calendar days from the Medicare remittance date before inquiring about the claim or resubmitting.

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately 14 business days to occur. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice.

Effective October 2013 Medicare crossover claims that are received from the provider within 30 days of the Medicare remit date will be rejected.

- Exception: VA provider claims and claims submitted with a GY modifier to indicate service is statutorily excluded by Medicare.
Provider Appeals Update

• 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.
Top 5 Reasons Claims are Rejected Institutional Claims

- Membership rejections
- Claim Filing Indicator Errors
- Service Date Errors
- CPT/HCPCS Errors
- *Security Errors

*Note: BCBSNC removed this editing in July
Top 5 Reasons Claims are Rejected
Professional Claims

• Membership Rejections
• Ancillary Provider Errors
• Rendering NPI not Registered
• *Security Errors
• Claim Filing Indicator Error

*Note: BCBSNC removed this edit in July.
2013 Updates
In January 2014, BCBSNC will expand the diagnostic imaging management program for our Medicare Advantage plans (Blue Medicare HMO SM and Blue Medicare PPO SM) to include echocardiography services, helping to uphold the same program benefits for our Medicare Advantage members.

Members enrolled in BCBSNC’s Medicare Advantage plans currently require diagnostic imaging prior approval for the following cardiac modalities:

- Myocardial perfusion imaging
- Cardiac CT/CTA
- Cardiac MRI
- Cardiac PET and blood-pool imaging
Echocardiography to Be Added to Blue Medicare Diagnostic Imaging Program January 1, 2014

Effective with dates of service on or after January 1, 2014, prior approval will also be required for Blue Medicare HMO and Blue Medicare PPO members, in advance of the following services being provided:

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

Ordering physicians for Blue Medicare HMO and Blue Medicare PPO members must contact AIM to obtain a prior approval number prior to scheduling an imaging exam for these outpatient services.
Echocardiography to Be Added to Blue Medicare Diagnostic Imaging Program January 1, 2014

Beginning December 16, 2013, ordering providers may begin requesting prior authorization for SE, TEE, or TTE for dates of service on or after January 1, 2014, in one of the following ways:

- Online through BCBSNC's provider website Blue eSM
- Through the AIM Specialty Health (AIM®) Call Center at 1-866-455-8414
The Affordable Care Act (ACA) required the following changes to Women’s Preventative Care benefits upon a group’s effective date/renewal date. All groups have renewed as of 8/1/2013:

- Human Papillomavirus (HPV) Testing for women >29 every 3 years
- Counseling on sexually transmitted infections (STIs) for sexually active women
- Annual HIV screening and counseling for sexually active women
- At least one wellness preventative care visit annually for adult women
- Breastfeeding support for pregnant/post-partum women
- Contraceptive methods and counseling
- Gestational Diabetes screening for pregnant women
- Annual screening/counseling for interpersonal/domestic violence for women

For complete details on the ACA changes and Preventative Care Services, please review the handout available on the Provider Portal at http://www.bcbsnc.com/assets/campaigns/public/preventive/pdf/hcr_preventive_services_grp.pdf
Privacy Regarding Member Self-Paid Services or Items

+ Under recently updated HIPAA privacy regulations, a member may 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.
State Health Plan Will Have Split Certificates in 2014

- Medicare-primary SHP retirees will be covered by either UnitedHealthcare or Humana in 2014

- Their dependents under the age of 65 will be covered by the State Health Plan, but they will have their own individual ID cards, regardless of age

- Effective January 1, 2014, spouses and dependents on these “split certificates” will be listed as the subscriber on their individual ID cards
Medicare Advantage Risk Adjustment Initiatives
Medicare Advantage (Medicare Part C)

Medicare Advantage combines Medicare Part A and Part B, plus other services as offered by individual plans (vision, dental services, fitness programs).

Medicare Advantage is offered by private health plans such as BCBSNC

- BCBSNC offers Blue Medicare HMO℠ and Blue Medicare PPO℠
- Members may purchase Part D drug coverage along with their Blue Medicare coverage or separately with traditional Medicare Parts A and B
Risk Adjustment Initiatives for 2013

Risk Adjustment initiatives support premium stabilization by ensuring that member risk is appropriately documented to CMS

- Plan often receives incomplete diagnostic data for a variety of reasons.
- Diagnostic data is shared with care management to support their efforts to develop a more complete member medical profile.
- CMS requires that the provider(s) and health plan(s) work together to provide complete and accurate data (42CFR 422.310).
2013 Retrospective Review Program

Is the collection of medical records that support medical risk during the last 6-months of 2012 and the first 6-months of 2013

+ Collection time period is July through December 2013
+ Retrospective vendor for 2013 is Outcomes Health Information Solutions
+ The responsibility of Outcome Health Information Solutions is to provide the listing of charts we review
Identification of members with likely care and/or documentation gaps. Members are targeted for intervention that includes increasing levels of contact to close the care gaps

+ Time period is late July through December 2013
+ Prospective vendor is Inovalon
Feedback

We value our relationship with our providers

- Introductory letter from Outcomes has BCBSNC contact information
- Customer service will address member and provider questions regarding Inovalon effort.
- You might receive an exit survey
- Provider Consultant will provide information to the RA team
- Reference: Alice Breeden, BCBSNC
  919-765-3588
  alice.breeden@bcbsnc.com
NCQA Change Regarding Allowed Documentation to Support HEDIS Follow Up After Hospitalization Criteria

- NCQA has changed their rules about what constitutes allowed documentation to support all HEDIS measures, including the “Follow Up After Hospitalization” measure for mental illness and substance abuse.
  - **Claims** for services rendered and sent to BCBSNC for payment.
  - **Note** from the member’s medical chart with identifying provider information attached.
  - **Encounter form** faxed to provider from Magellan requesting confirmation of services rendered.

- For 2014 HEDIS measures (2013 dates of service), only member follow-up visits supported by a claim, note or encounter form will be allowed as evidence of aftercare follow-up treatment.
Tips to Ensure Successful Follow-Up Care After Hospitalization

+ Members discharged from an inpatient level of care should have a **scheduled, verifiable follow-up appointment with a participating behavioral health provider/or psychiatrist within seven days of discharge** to ensure aftercare compliance and prevent readmissions.

+ An aftercare appointment with the member’s primary care physician should not be the only appointment in place for a member discharging from an inpatient level of care.

+ BCBSNC delegates mental health and substance abuse administration to Magellan Health Services for many of its customers.
Health Care Reform
Health Care Reform in a Nutshell

The Affordable Care Act (ACA):

+ Mandates coverage
+ Mandates insurance reform
+ Fundamentally changes how insurance is purchased
  - Health Insurance Marketplaces/Exchanges
  - Think: Expedia for health insurance
Role of the Exchange

+ Exchange serves many functions, including:

- Allowing individuals and small groups to calculate and compare products
- Providing standardized information about coverage and pricing
- Determining eligibility for and connecting purchasers with potential subsidies.
- Exchange changes what we sell and how we sell it
Federal Subsidies

+ Subsidies will be available to low- and middle-income Americans purchasing insurance from an Exchange

+ Subsidies will likely mask premium increases
  - They do not lower premiums
  - They shift the burden of payment from individuals to the government

+ Subsidy eligibility
  - Between 100% and 400% Federal Poverty Level

+ At $465 billion, the most expensive part of the ACA
Changes to our Plans: Rating Changes

+ Guarantee Issue
+ Modified Community Rating

(does NOT apply to large group/ASO/Grandfathered Plans)

+ No underwriting for health status or gender and can adjust premiums only in certain situations
  - Family Structure
  - Age
    - cannot charge the oldest people we insure more than 300% what we charge the youngest person
  - Tobacco Use
    - Cannot charge tobacco users more than 50% of what we charge people who don’t use tobacco
  - Geographic Rating Area
Changes to our Plans - Essential Health Benefits (EHB)

+ All non-grandfathered, insured small group and individual plans must cover essential health benefits

+ State specific benchmark plan
  - Benchmark plan for NC is BCBSNC Blue Options PPO for Small Group

+ 10 categories of services including
  - Maternity and newborn care (BCBSNC now requires for individual – no riders)
  - Rehabilitative and Habilitative
  - Pediatric services (includes dental and vision)

+ Not offered as standard option for large group
HealthCare Reform Questions

can be directed to: www.nchealthreform.com
Provider Survey
ICD-10: Be Ready!
ICD-10 will change everything.

Physicians
- **Documentation:**
  The need for specificity dramatically increases by requiring laterality, stages of healing, weeks in pregnancy, episodes of care, and much more.
- **Code Training:**
  Codes increase from 17,000 to 140,000. Physicians must be trained.

Nurses
- **Forms:**
  Every order must be revised or recreated.
- **Documentation:**
  Must use increased specificity.
- **Prior Authorizations:**
  Policies may change, requiring training and updates.

Lab
- **Documentation:**
  Must use increased specificity.
- **Reporting:**
  Health plans will have new requirements for the ordering and reporting of services.

Billing
- **Policies and Procedures:**
  All payer reimbursement policies may be revised.
- **Training:**
  Billing department must be trained on new policies and procedures and the ICD-10-CM code set.

Clinical Area
- **Patient Coverage:**
  Health plan policies, payment limitations, and new ABN forms are likely.
- **Superbills:**
  Revisions required and paper superbills may be impossible.
- **ABNs:**
  Health plans will revise all policies linked to LCDs or NCDs, etc., ABN forms must be reformatted and patients will require education.

Managers
- **New Policies and Procedures:**
  Any policy or procedure associated with a diagnosis code, disease management, tracking, or PQRI must be revised.
- **Vendor and Payer Contracts:**
  All contracts must be evaluated and updated.
- **Budgets:**
  Changes to software, training, new contracts, new paperwork will have to be paid for.
- **Training Plan:**
  Everyone in the practice will need training on the changes.

Front Desk
- **HIPAA:**
  Privacy policies must be revised and patients will need to sign the new forms.
- **Systems:**
  Updates to systems are likely required and may impact patient encounters.

Coding
- **Code Set:**
  Codes will increase from 17,000 to 140,000. As a result, code books and styles will completely change.
- **Clinical Knowledge:**
  More detailed knowledge of anatomy and medical terminology will be required with increased specificity and more codes.
- **Concurrent Use:**
  Coders may need to use ICD-9-CM and ICD-10-CM concurrently for a period of time until all claims are resolved.
ICD-10 Facts

+ The industry-wide conversion to ICD-10 will occur on October 1, 2014. 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 10/1/2014, it will require an ICD-9 code, if after 10/1/2014, it will require an ICD-10 code.
ICD-10 Facts

+ If your practice is submitting HIPAA 4010 claims to your clearinghouse, you MUST convert to HIPAA 5010 claims prior to October 1, 2014. 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 inquiries, 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, 2014.
- Reference the CMS website on a regular basis for updates, guides, tools and bulletins.

http/www.cms.gov/ICD10
## ICD-10 Impact Assessment

<table>
<thead>
<tr>
<th>Degree of ICD-10 Change</th>
<th>Provider Specialty</th>
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</table>
| High                    | *OB/ Gyn*  
*Orthopaedics*  
*Psychiatry*  
*Gastroenterology*  
*Physical Therapy*  
*Cardiology*  
*General Surgery* |
| Medium                  | *Primary Care*  
*Lab*  
*Optometry*  
*Dermatology*  
*Ear, Nose, Throat*  
*Durable Medical Equipment* |
| Low                     | *Dental*  
*Convenience Care*  
*School Clinic* |
BCBSNC Outreach

+ **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 10/1/14.

+ **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
Be Ready – Get Paid

- All electronic or paper-based transactions for services on or after October 1, 2014, 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, 2014, 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.
Blue Cross and Blue Shield of North Carolina (BCBSNC) is taking the necessary steps to ensure that all systems and processes will be compliant by October 1, 2014.

BCBSNC is evaluating the provider testing approach and plans to be ready to begin testing with selected providers by first quarter 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.
ICD-10: Industry Resources

- BCBSNC
  - [http://www.bcbsnc.com/content/providers/legislative/icd10.htm](http://www.bcbsnc.com/content/providers/legislative/icd10.htm)
- CMS
- AHA
- AHIMA
  - [http://www.ahima.org/icd10/](http://www.ahima.org/icd10/)
- AAPC
- NCHICA
  - [http://www.nchica.org/HIPAAAResources/icd10.htm](http://www.nchica.org/HIPAAAResources/icd10.htm)
Tools and Resources
Provider Portal

Have you visited us on the Web lately?

Highlights of the **Provider Portal** include:

- Current [news & information](#)
- Provider Oriented information [Education & Learning Center](#) and [eManuals](#)
- Interactive Provider [Forms](#) and other helpful tools
- Online [Provider Newsletter](#)
- Quick access to [BlueCard®](#), [Blue Medicare®](#), and [Dental Blue®](#) information
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:

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Subscribe ⋈ Unsubscribe

Submit

Powered by

ExactTarget.
Your PSA’s are able to assist with:

- Providing you information on how to obtain your fee schedule (if you are unable to retrieve via Blue e)
- Making any necessary demographic changes – notice address, billing address, etc.
- Add/Remove providers from your practice
- Questions

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Questions