



Human Services Committee – January 7, 2014

Good Afternoon Chairman Damschen and members of the Human Services Committee, for the record, I am Megan Houn from Blue Cross Blue Shield of North Dakota.

We have been asked to appear today to summarize coverage changes resulting from the Affordable Care Act (ACA) as it impacts behavioral health and addictions benefits. Blue Cross Blue Shield of North Dakota continues to seek solutions that provide the right care, at the right time, at the right place and at the right cost for our members. In addition, BCBSND continues to believe that providing psychiatric and addictions care is an important component of our mission. We intend to continue to provide safe, effective and affordable behavioral health and addictions benefits to our members, while remaining good stewards of their premium dollars.

Impact of health care reform on health insurance plans

The issue of BCBSND coverage recalibration was raised at the previous meeting of this committee. I appreciate the opportunity to provide some context and clarity surrounding the Essential Health Benefits (EHB) and a brief history on mental health coverage at BCBSND.

As you know, the ACA requires all health plans sold on the Health Insurance Marketplace and all new products in the individual and small group markets sold off the Marketplace to include a minimum level of coverage as of January 1, 2014. The Essential Health Benefits (EHB) must include a minimum level of coverage in 10 categories, including: outpatient care, inpatient care, emergency care, mental health services, prescription drug coverage, rehabilitative and habilitative services, preventive/wellness services, laboratory services, pediatric care and maternity/newborn care.

In October 2011, and prior to requiring each state to choose a Benchmark, the Institute of Medicine (IOM) committee of the National Academy of Sciences released a report which developed a framework for defining minimum “essential” benefits. Each state has since identified its own EHB benchmark plans complete with required benefits coverage.

The IOM recommended taking a balanced approach to determining EHB that takes into consideration affordability of coverage and evidence-based, medically-effective services. Benchmark EHB plans offered on the “exchange” were to have been models for other plans to follow, but flexibility has been allowed. Exchange plans must fit in one of four metallic levels of actuarial coverage.

In time, EHB requirements will likely be updated by the federal government as new evidence-based data and more specific focus areas are identified. Because the future addition of new benefits too will add costs, per the ACA, costs must be considered in initial and any future EHB updates to ensure affordability and protect the intent of the ACA.

EHB will forever change relationships between providers, payers and patients. Providers and insurers are being held accountable to objective requirements in an attempt to measure the value of services provided to patients.

Doctors and insurers are beginning to look at health care costs, quality, collaboration and transparency in different ways. Blue Cross Blue Shield of North Dakota (BCBSND) is beginning to reimburse providers more on achieving quality benchmarks and less on quantity of services provided (or the traditional fee-for-service model). Many insurers and providers nationwide are forming Accountable Care Organizations (ACOs) to help better coordinate care. Programs such as BCBSND's MediQHome, a medical home model that helps doctors and providers better coordinate care for patients with chronic conditions such as diabetes and hypertension, are gaining momentum.

Health insurance works by pooling risk across a group or population. Medically-necessary care is paid for through shared resources prompting the question: "Which services should be paid for using the group's shared resources?" The U.S. health care system continues to search for ways to improve performance, quality and health outcomes. It will continue to evolve, adding ACOs, MediQHomes and total cost of care reimbursement arrangements to place more emphasis on patients and better coordinating care.

In 2011, the ACA required each state to choose a benchmark plan from a list of plans defined by the law to establish specific benefits for 2014 and 2015. The North Dakota Insurance Department (NDID) reviewed four options, including: Sanford Health Plan product; the state employee plan; the federal employee plan; and the plan with the most members in the state (BCBSND plan). The Department recommended the Sanford Health Plan health insurance product as North Dakota's EHB benchmark plan. The legislature voted to accept the Department's recommendation during the 2011 Special Session.

Historically, BCBSND health plans offered richer benefits than those included in the Sanford benchmark plan and the plans we submitted for consideration as the Benchmark included these benefits. BCBSND expended significant effort to see that the people of North Dakota would have excellent, affordable, quality-driven health insurance with significant depth of coverage through the products we submitted for consideration as the Benchmark. The Benchmark which was chosen did not have this depth, and our metallic products therefore, must adjust to the Benchmark. To conform to the provisions of the ACA including EHB, BCBSND will now be recalibrating its medical, surgical, mental health and addictions benefits.

Which plans are affected?

These benefits changes will be applicable to all metallic products, both on and off the Health Insurance Marketplace, in the individual and small group markets. Federal Employee Program plans, non-grandfathered plans in the large group markets, and grandfathered plans (those policies issued prior to March 23, 2010) are not impacted. Attached to my testimony is a copy of the BCBSND HealthCare News from October 2013. HealthCare News is published as a service to health care providers. Beginning on page three, you can find a list of coverage changes.



BCBSND understands and has been equally concerned about the implications of the benchmark plan chosen for members who have been accustomed to more covered services in their health insurance. As a member-owned, not-for-profit insurance company, we have also heard clearly from our members that health insurance premiums are unsustainable at the current rates.

We have pledged to collaborate with providers to determine best practices to ensure all patients receive the highest quality, most appropriate care, at the lowest rates possible. Consequently in 2011, BCBSND added additional resources in the behavioral health section as one example of collaboration and our commitment to a sustainable health care system in North Dakota.

North Dakota Solution

We are committed to working with state leaders, providers, and regulators to find solutions to meet the health care needs of North Dakotans. As you are aware, a legislative study is underway in the Health Care Reform and Review Committee, led by Chairman Keiser, to study the immediate needs and challenges of the North Dakota health care delivery system and the feasibility of developing a plan for a health care model that will comply with federal health care reform in a manner that will provide high-quality, accessible, and affordable care for North Dakota citizens, taking into account the ongoing impact that federal health care reform under the Affordable Care Act is having on state delivery of health care.

We continue to believe that a state driven solution may be the best fit for our members and are committed to working with each of the legislative committees to identify those solutions.

Ultimately, we all recognize that healthcare delivery is fragmented and in need of improvement. BCBSND is committed to working in partnership with providers and policymakers to address difficult issues as we work to improve delivery for the future.

Mr. Chairman and Committee members thank you for the opportunity to appear before you and I am willing to answer any questions you may have.

About Blue Cross Blue Shield of North Dakota

BCBSND is a member-owned, not-for-profit independent licensee of the Blue Cross and Blue Shield Association.

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Coding and Billing

Chemical Dependency Revenue Code – Institutional

A new revenue code 0953 – Chemical Dependency (Drug and Alcohol) effective October 1, 2013, has been created to report the intensity of service on inpatient claims with Type of Bill (TOB) 086X (residential) or outpatient claims with TOB 089X (special facility) according to the National Uniform Billing Committee.

Blue Cross Blue Shield of North Dakota will not allow revenue code 0953 to be billed for any TOB. Claims will be returned to the provider instructing them to bill according to the established coding and billing guidelines for residential treatment center (RTC) and intensive outpatient program (IOP) published in the HealthCare News Bulletin 352.

BlueCard

Ancillary Claims - Update

Blue Cross Blue Shield of North Dakota (BCBSND) will deny claims for ancillary services filed to the incorrect plan.

Generally, health care providers file claims for Blue Cross and Blue Shield patients to the local Blue Plan. However, in unique circumstances, claims filing directions differ based on the type of provider and service.

Ancillary claims incurred by a participating provider in a contiguous county may be filed directly to the local Plan, but solely for members who live or work in this service area. Claims for all other members must be filed as defined for ancillary services.

Ancillary providers are Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies, and Specialty Pharmacy providers. The local Blue Plan for ancillary services is defined as follows:

Independent Clinical Laboratory (Lab) - The plan in the state where the specimen was drawn.

Durable/Home Medical Equipment and Supplies (DME) – The plan in the state where the equipment was shipped to or purchased at a retail store. “Shipped to” takes priority over where the equipment was purchased. The Place of Service (POS) will identify where the claim should be filed:

- 12(home); 04(homeless shelter); 09(prison); 13 (assisted living); 14(group home); 34(hospice); 55 (residence substance abuse treatment facility) - file to the plan in the state where the item was shipped to
- 11 - Item was received in the provider’s office - file to the plan in the state where the provider is located
- 17 - Item was purchased at a retail location - file to the plan in the state where the retail provider is located

Specialty Pharmacy -The plan in the state where the ordering physician is located.

This policy does not apply to the Federal Employee Program (FEP).

ProviderType	How to file (required fields)	Where to file	Example
<p>Independent Clinical Laboratory (any type of non hospital based laboratory)</p> <p>Types of Service include, but are not limited to:</p> <ul style="list-style-type: none"> Blood, urine, samples, analysis, etc. 	<p>Referring Provider:</p> <ul style="list-style-type: none"> Field 17B on the CMS 1500 Health Insurance Claim Form, or Loop 2310A (claim level) on the 837 Professional Electronic Submission 	<p>File the claim to the Plan in the state where the specimen was drawn.</p> <p>Where the specimen was drawn will be determined by which state the referring provider is located.</p>	<p>Blood is drawn in a lab or office setting located in North Dakota.</p> <p>Blood analysis is done in Minnesota.</p> <p>File to: Blue Cross Blue Shield of North Dakota.</p> <p>Claims for the analysis of a lab must be filed to the Plan in the state where the specimen was drawn.</p>
<p>Durable/Home Medical Equipment and Supplies (D/HME)</p> <p>Types of Service include, but are not limited to:</p> <ul style="list-style-type: none"> Hospital beds, oxygen tanks, crutches, etc. 	<p>Patient's Address:</p> <ul style="list-style-type: none"> Field 5 on the CMS 1500 Health Insurance Claim Form, or Loop 2010CA on the 837 Professional Electronic Submission <p>Ordering Provider:</p> <ul style="list-style-type: none"> Field 17B on the CMS 1500 Health Insurance Claim Form, or Loop 2420E (line level) on the 837 Professional Electronic Submission <p>Place of Service:</p> <ul style="list-style-type: none"> Field 24B on the CMS 1500 Health Insurance Claim Form, or Loop 2300, CLM05-1 on the 837 Professional Electronic Submission <p>Service Facility Location Information:</p> <ul style="list-style-type: none"> Field 32 on the CMS 1500 Health Insurance Claim Form, or Loop 2310C (claim level) on the 837 Professional Electronic Submission 	<p>File the claim to the Plan in the state where the equipment was shipped to or purchased in a retail store.</p> <p>The "shipped to" location takes priority over where the equipment was purchased.</p> <p>Example: If the equipment is purchased in Minnesota and shipped to North Dakota, file the claim to North Dakota.</p> <p>If the equipment is purchased in Minnesota and the member leaves the retail store with the product, submit the claim to the Minnesota plan.</p>	<p>A. Wheelchair is purchased at a retail store in North Dakota. File to: BCBSND</p> <p>B. Wheelchair is purchased on the internet from an online retail supplier in Minnesota and shipped to North Dakota. File to: BCBSND</p> <p>C. Wheelchair is purchased at a retail store in Minnesota and shipped to North Dakota. File to: BCBSND</p> <p>D. Wheelchair is purchased at a retail store in Minnesota and the member leaves the store with it. File to: Minnesota</p>
<p>Specialty Pharmacy</p> <p>Types of Service:</p> <p>Non-routine, biological therapeutics ordered by a health care professional as a covered medical benefit as defined by the member Plan's Specialty Pharmacy formulary. Include, but not limited to: injectable, infusion therapies, etc.</p>	<p>Referring Provider:</p> <ul style="list-style-type: none"> Field 17B on the CMS 1500 Health Insurance Claim Form, or Loop 2310A (claim level) on the 837 Professional Electronic Submission 	<p>File the claim to the Plan in the state where the ordering Physician is located.</p>	<p>Patient is seen by a physician in North Dakota who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in Arizona where the member lives for 6 months of the year.</p> <p>File to: BCBSND</p>

The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.

Providers are encouraged to verify Member Eligibility and Benefits by calling the phone number on the back of the Member ID card, or 800-676-BLUE, prior to providing any ancillary service.

Providers that utilize outside vendors to provide services (example: sending blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) should utilize in-network participating Ancillary Providers to reduce the possibility of additional member liability for covered benefits. Contact BCBSND for a list of in-network participating providers.

Members are financially liable for ancillary services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.

Providers who wish to establish Trading Partner Agreements with other Plans should contact BCBSND to obtain additional contact information.

If you have any questions about where to file your claim, contact BCBSND Provider Service at 800-368-2312.

Benefit Plan Rewrite

ACA Essential Health Benefits regulations lead to BCBSND coverage changes

The Affordable Care Act (ACA) requires that all health plans sold both on and off the Health Insurance Marketplace, offer a minimum level of coverage of Essential Health Benefits (EHB) in 10 categories: outpatient care, inpatient care, emergency care, mental health services, prescription drug coverage, rehabilitative and habilitative services, preventive and wellness services, laboratory services, pediatric care, maternity and newborn care. Due to this ACA mandated requirement, BCBSND has created new metallic health plans that are available both on and off the Health Insurance Marketplace. These metallic products will be the ONLY products offered in the individual and small group markets in 2014. As a result, individuals enrolled in BCBSND's existing non-grandfathered plans (individual or group policies issued after March 23, 2010) in the individual and small group markets will transition into the new metallic products in 2014. This transition will take place on the group anniversary, or for individual policy holders on the rate anniversary, which occurs in May and October. By the end of 2014, all of BCBSND's non-grandfathered business in the individual and small group markets will be enrolled into a metallic product to ensure compliance with the Affordable Care Act.

A Sanford Health Plan health insurance product was selected by the North Dakota Department of Insurance as the benchmark plan for the state of North Dakota, to provide a baseline of minimum coverage that other plans sold on the Health Insurance Marketplace must meet. Historically, BCBSND health plans offered richer benefits than those included in the Sanford benchmark plan. To conform to the provisions of the ACA including EHB, BCBSND will now be recalibrating its medical, surgical, mental health and addictions benefits. These benefit changes will be applicable to all metallic products, both on and off the Health Insurance Marketplace, in the individual and small group markets. Federal Employee Program (FEP) plans, non-grandfathered plans in the large group markets, and grandfathered plans (policies issued prior to March 23, 2010) are not impacted. Please contact BCBSND Provider Services at 800-368-2312 or 701-282-1090 for information about which specific plans are impacted.

Here are some of the coverage changes:

Behavioral health **Please see the article on page 4 for additional information regarding behavioral health changes*

- Residential treatment excluded for those older than 21
- Family therapy no longer covered

Infertility

- Infertility services no longer covered

Physical Therapy

- Physical therapy, occupational therapy and speech therapy will be limited to 30 visits per year
- There will no longer be a preauthorization requirement for rehabilitative physical therapy
- Physical therapy for members age 65 and older living in communal homes and at risk for falls will be covered at 100% of allowed charge, to comply with United States Preventive Services Task Force recommendations

Chiropractic

- Chiropractic services will be limited to 20 visits per year

Nursing care

- Home health care limited to 40 visits per year
- Skilled nursing facility visits limited to 30 visits per year

Weight loss

- No longer allowing coverage for weight loss medications – BCBSND members with current prescriptions for weight loss medications will be allowed continuing coverage until current prior approval expires

Sleep studies

- Sleep studies require prior approval if performed at a facility that is not accredited by the American Academy of Sleep Medicine

Annual and lifetime dollar limits for EHB

- Lifetime dollar limits have been removed from benefits that fit within EHB requirements

Genetic testing

- Will no longer be allowed when performed without symptoms or high risk factors of a heritable disease
- Knowledge of genetic status cannot impact treatment choices, screening for disease or reproductive choices
- Genetic testing can't be done as the result of direct marketing to consumers and can't be performed without the direction of a physician

Behavioral Health Changes

The following information is a brief summary of the benefit plan changes for Behavioral Health effective August 1, 2013, and on group anniversary thereafter, unless otherwise indicated. Not all benefit plan changes apply to all products. **This does not apply to FEP.** This summary should not be used to determine whether a member's health care expenses will be paid. The written benefit plan governs the benefits available. Providers may want to verify member benefit eligibility before providing services. Covered services are subject to benefit plan cost sharing amounts, unless otherwise indicated.

Autism Spectrum Disorders –The benefit plan language was revised to reflect the current medical policy that continues to exclude Applied Behavioral Analysis as a non-covered service.

Family Therapy – *No benefits for family therapy will be available for the metallic plans, both on and off the Health Insurance Marketplace. This is effective starting January 1, 2014 with the group anniversary, or for individual policy holders on the rate anniversary, which occurs in May and October. Benefits will continue to be available for BCBSND's non-metallic plans (which include the Federal Employee Program (FEP) plans, non-grandfathered plans in the large group markets, and grandfathered plans).*

Social Detoxification and Ambulatory Detoxification (American Society for Addiction Medicine (ASAM) Levels III.2-D, II-D and I-D) – No benefits are available for social detoxification under ASAM level III.2-D: Clinically Managed Residential Detoxification, ASAM level II-D: Ambulatory Detoxification with Extended Onsite Monitoring, and ASAM level I-D: Ambulatory Detoxification without Extended Onsite Monitoring.

Inpatient Detoxification (ASAM Levels III.7-D and IV-D) – Benefits for services are available when medically monitored and managed under inpatient ASAM levels III.7-D: Medically Monitored Inpatient Detoxification and IV-D: Medically Managed Inpatient Detoxification.

Detox Pharmacological management – No benefits are available for non-inpatient pharmacological management, including Outpatient, Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP) setting, or Residential Treatment detoxification.

Psychiatric Intensive Outpatient (IOP) – No benefits are available for psychiatric IOP effective 1/1/14.

Substance Abuse Residential Treatment Centers (RTC) – *No benefits for ASAM III.5 RTC, ASAM III.3 RTC and ASAM III. 1 RTC are available for members over age 21 for the metallic plans, both on and off the Health Insurance Marketplace. This is effective starting January 1, 2014 with the group anniversary, or for individual policy holders on the rate anniversary, which occurs in May and October.*

The following benefit changes apply for all ages for BCBSND's non-metallic plans (which include the Federal Employee Program (FEP) plans, non-grandfathered plans in the large group markets, and grandfathered plans). This is effective January 1, 2014.

- Benefits will be available ONLY for ASAM III.5 RTC
- Benefits will no longer be available for ASAM III.3 RTC
- Benefits will no longer be available for ASAM III.1 RTC
- If applicable, Case Management will be available to assess and potentially meet the need for a "sober or abstinent bed"

The above four bulleted items will also apply to those members under age 21 in the metallic plans, both on and off the Health Insurance Marketplace. This is effective January 1, 2014.

Educational Opportunities

AAPC Fall Coding Conference - Fargo

The Red River Valley Chapter of the American Academy of Professional Coders (AAPC) is sponsoring the Annual Fall Coding Conference Saturday, October 19, 2013, from 8:00 am to 4:00 pm in the Dakota Rooms at Blue Cross Blue Shield North Dakota, 4510 13th Ave S, Fargo, ND 58121.

Guest Speakers will include:

- Fran McNicholas, RHIT, CPC, CPCD, PCS, CDC
- Dr. Ari Taheri, Gastroenterologist
- Heather England, PT, DPT
- Diane Halvorson, RPhTech, CPhT
- Dr. Rose Brakke, Audiologist
- Emily Richard, Hearing Instrument Specialist

This conference has been approved by the American Academy of Professional Coders (AAPC) for 6.5 CEU credits.

Conference Agenda:

- 8:00-8:30: Registration
- 8:30-10:30: Faith McNicholas, AHIMA approved ICD-10 Trainer – Impact of ICD-10
- 10:30-10:45: Break
- 10:45-12:15: Dr. Rose Brakke and Emily Richard – Diseases of the auditory system
- 12:15-12:45: Lunch
- 12:45-1:45: Dr. Ari Taheri, MD – Crohns and Ulcerative Colitis in pregnancy
- 1:45-2:45: Heather England, PT, DPT – Physical Therapy with Osteoporosis
- 2:45-3:00: Break
- 3:00-4:00: Diane Halvorson, RPhTech, CPhT – National Drug Codes

Registration Information

Registration Fee: \$50.00 (non-refundable) includes continental breakfast, lunch, snacks, and door prizes.

Registration deadline October 12, 2013. Registrations must be received no later than October 12, 2013. Seating is limited to the first 100 registrants. Reservations will be confirmed upon receipt of payment.

Registration Form - Fargo Coding Conference, October 19, 2013

Name _____
Address _____
City/State/Zip _____
Phone _____
E-mail _____

Mail registration form and fee (checks made payable to RRV AAPC Local Chapter) to:

**RRV AAPC Local Chapter
PO Box 244
West Fargo, ND 58078**

Notes:

Notes:

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