2009 SENATE INDUSTRY, BUSINESS AND LABOR

SB 2397

# 2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2397

Senate Industry, Business, and Labor Committee

☐ Check here for Conference Committee

Hearing Date: February 10, 2009

Recorder Job Number: 9085, ~~9089~~

Committee Clerk Signature Troy Schuchard

Minutes:

**Chairman Klein:** Called the committee to order, all members' presents.

**Bruce Levi:** Representing North Dakota Medical Association and I am testifying in support of SB 2397. (See attachment #1)

**Senator Andrist:** if a large insurance carrier negotiates a contract with a provider, does the provider have to every insurance carrier the same contract term?

**Bruce Levi:** No. Under the legislation passed in 1999, there is a provision that would prohibit what we call "most favored nation" provisions that relate specifically to the payment that is provided. If there isn't an opportunity to negotiate a contract, shouldn't there be fair contracting standards in place to address issues like that and I think in 1999 that was one of the items we were successful at getting into law, that would not allow insurance carriers to require you give the lowest amount that you agree to discount with another carrier.

**Senator Andrist:** I didn't understand your answer, If you give a contract with a discount to BC/BS, do you have to give the same discount to "Potter Insurance Company"?

**Bruce Levi:** No

**Senator Andrist:** Does this bill cover that?

**Bruce Levi:** The only area that we talked about here and in the past about contract provisions carried over to other providers, basically in 2 areas; one is in the "most favored Nation" provision that I have talked about, the other provision would be the rental agreement provision in this bill that I have talked about. My understanding is that BC/BS does engage in this practice, but there are other carriers that do engage in the practice selling the discounts that they garner from providers to other insurance carriers and other entities and then they sell those downstream in the insurance market. These providers are not aware of these rental agreements until they treat a patient and find out later when they are being paid on their claim to the other insurance company that that has occurred.

**Senator Andrist:** What if the insurance carrier negotiates a fee schedule or adopts a fee schedule, and then the insurance carrier wants to sell a low-ball policy, can they have a different fee schedule for that policy?

**Bruce Levi:** The insurance carrier can negotiate any fee schedule with the health care provider, hospital, clinic, or what have you. I think what this bill does is that if there is negotiation and a contract, that the payment terms are spelled out specifically in the contract and incorporated as part of the contract, so they cannot be unilaterally changed between contracts.

**Senator Andrist:** My question was can the insurance carrier provide different payment levels for different policy?

**Bruce Levi:** I suspect if the insurance carrier wanted to negotiate independent contracts with each individual provider in North Dakota at different levels, they could certainly do so.

**Senator Andrist:** If the carrier and a physician group negotiate a contract, is there anything that requires that insurance company to have a similar contract with all providers? Or offer to other providers?

**Bruce Levi:** The contracts need to be uniform in the respect that they are across the state.

**Chairman Klein:** You mentioned 8 fair contracting principles. Should we have addressed these issues sometime back or what has brought this to a head today? Where are we and how did we get here.

**Bruce Levi:** The issue has been out there. From the standpoint of the Medical Association, we have looked at this issue with former Insurance Commissioner Pullman, we had legislation drafted in 2001. In 1999, we had addressed some of the areas that we had concerns with in terms of the laws that I indicated are already on the books. In 2001, we were particularly concerned about notification of changes to contractual terms as well as specifically having notice of changes. We realized that under the contracts, BC/BS could unilaterally announce changes in payment. I think that really raised the issue again from our standpoint.

**Chairman Klein:** You would say that the Insurance Commissioner has no oversight over these issues. I would have thought that he would have had some ability to step in and say wait a minute, that's not right!

**Bruce Levi:** I'm sure the Insurance Dept. could address that more specifically. We need a more definitive language in the code that defines specifically the standards and the authority of the Insurance Commissioner to do this and look at contracts and decide whether or not, particularly in our environment in North Dakota with the dominant carrier, whether or not we have a fair environment. In our view, whenever BC/BS is the dominant carrier, it makes public policy because it impacts everyone across the state, medical practice, management, and payment methodology that are used by BC/BS. These terms need to be disclosed in the contracts. We need the ability to go somewhere when changes are made.

**Senator Horne:** Do you also speak for hospitals and providers?

**Bruce Levi:** This morning I am speaking for NDMA.

**Senator Potter:** We have heard testimony that there are 1400 or so physicians in North Dakota, how many of those are in fulltime practice in North Dakota?

**Bruce Levi:** The number 1400 is the number of fulltime practicing physicians.

**Senator Potter:** How many of those 1400 physicians participate in BC/BS?

**Bruce Levi:** I believe that would be a good question for them. I suspect it to be like 99.9% or something close to that. Most physicians participate in BC/BS.

**Senator Potter:** It is a voluntary choice, isn't it?

**Bruce Levi:** I think with the market share BC/BS has obviously it is the dominant carrier, as a result one really has to participate in BC/BS if you are going to do business with patients in North Dakota.

**Senator Potter:** You can still do business with the doctors and still have your BC/BS pay for it. I have had that in the past with non-participating doctors. So what's the downside?

**Bruce Levi:** I suspect it is all in the payment schemes and how you collect your reimbursement as a provider. Your non-participating provider's share of reimbursement is less than what it would be with a participating provider. The remainder of the balance would have to be collected from the patients.

**Senator Potter:** I think everything you said is accurate, but not clear. My understanding of participating physicians is they can charge anything they want, but BC/BS will set their reimbursement rate and they will pay. But if you are not a participating physician, then they pay the patient and you have to get the money from the patient...but you can charge anything you want.

**Bruce Levi:** I would have gone back and look at our balance bill laws, it is my understanding that you would not be able to go back to the patient.

**Senator Potter:** If you do not participate, then BC/BS has nothing to say about it.

**Senator Potter:** How do physicians compete?

**Bruce Levi:** From a provide standpoint there is competition North Dakota with respect to health care all across the state. If providers do not have the ability to negotiate directly with an insurance carrier with a fair contract, that is where the need comes in for fair contracting standards because of the lack of competition.

**Senator Potter:** How do North Dakota physician salaries compare to other states surrounding our state.

**Bruce Levi:** I could get that information for you. We compete at a national level. One could argue that the rural areas have to increase their contracts to entice people to move to these remote locations and fill multiple roles. Overall the salaries are competitive.

**Senator Potter:** In comparison how are BC/BS rates of reimbursement compared to rates physicians receive from Medicare and Medicaid for equivalent services? Which one pays best?

**Bruce Levi:** I could get that. We had a study last year and it compared BC/BS and Medicare with WSI. My written testimony includes some information about how BC/BS compares to commercial rates in the region, and they are below commercial rates in the region.

**Senator Potter:** In general, do you feel physicians are adequately compensated in North Dakota?

**Bruce Levi:** We have a lot of homegrown physicians in North Dakota, and those who want to stay in North Dakota will accommodate to the lifestyle they want and where they are. In the rural areas, we have to compete on a national market. One could argue that they have to be in order to continue to be competitive and continue to do business in North Dakota.

**Senator Potter:** I don't know if this is correct, but I heard that physicians are the highest paid occupation in the state? Would you say that is correct?

**Bruce Levi:** From an economic development standpoint, these are good jobs and these are good people to bring into North Dakota for health care purposes. There needs to be adequate resources going into our healthcare system to sustain our healthcare system.

**Senator Potter:** So things are not bad in this state for physicians, but this legislation is offered because you are looking forward and you are looking back at last summer. In looking back at last summer, my question is "are you saying that the commissioner did not have the authority that he exercised?

**Bruce Levi:** It is my understanding that some have asserted that he did not.

**Senator Potter:** The business about the sale of discounts doesn't seem to be a practice we should be doing either up-stream or down-stream, BC/BS could be stuck honoring a discount granted to another carrier that signed up a physician. With regards to access to payment terms, you want access to the payment terms. What's the need for access to these payment terms?

**Bruce Levi:** There are a couple of reasons, first is to make it a part of the contract, second is so people can do business, understand that this is the payment system and there are methodologies that are used if they make amendments, we call this editing or bundling, or doing things with the coding process that changes what a facility is paid. Folks need to know that. What is needed is to some degree, what was provided in the contract was going to hold into the future and if there is a payment process of methodology, it is stated and referred to in the contract.

**Senator Potter:** Who can restrain health care costs in North Dakota if it's not BC/BS?

**Bruce Levi:** It is a 3 or 4 legged stool, in 1993 we made it law that we didn't want BC/BS practicing medicine. How do they practice medicine? Through medical management policy or

reimbursement. A dominate carrier such as BC/BS, has the ability to change the way physicians practice medicine and deal with patients.

**Mike Fix:** Director of the Life and Health Division and the Life and Health Actuary for the North Dakota Insurance Dept, testified in support of SB 2397. (See attachment #2)

**Chairman Klein:** Maybe you can help me understand the issue at hand. The issue was that BC/BS asked for a rate increase because they were spending more money than they were taking in, did they then say we don't have the money so we are going to reduce those payments so we can get to the end. Am I kind of close here?

**Mike Fix:** When the company filed for a rate increase, they asked for a 14.8% increase on their bank deposit which is their individual policy holders, included in that were the assumptions used to justify that request. Specifically in this request was an trend assumption of 11%. The increase in cost of benefits, a key component in that trend assumption is the increase in provider reimbursements. The company had assumed a 5.6% increase in provider reimbursements.

Shortly after that, the company announced they would withhold 2.5% of the 5.6% until the end of 2008. It was stated in the announcement the company would pay all or part of the 2.5% provider withhold. What that said to us is that there is the opportunity to not pay the 2.5% out due to the language used in the announcement stated "all or part" of the provider withhold. At that point, it invalidated the justification for the 14.8% rate increase. What this said to us is we don't have the ability to adequately review the rate increase request. At that point, the commissioner said until that part gets fixed, we cannot review the rate increase request. So that has brought us to where we are today. It is my understanding the provide agreement issue has been resolved as of a couple weeks ago.

**Chairman Klein:** Who are the shareholders of BC/BS of North Dakota?

**Mike Fix:** The BC/BS members of North Dakota.

**Senator Andrist:** What happens when BC/BS a develop contract provision, are they bound to give that same contract to all providers? Do other insurance carriers have to abide by that contract, or can the provider charge more to another carrier? Does the rate they contract transferrable to other providers? Does BC/BS have the power to negotiate a contract with Med Center One and then not give the same rate to a physician in Kenmare North Dakota?

**Mike Fix:** They do have that ability, I'm not sure they do that. The numbers that come to us is an overall increase in provider reimbursements. That's not to say one couldn't get more and one couldn't get less because there are a number of things that affect a particular providers reimbursement. There is nothing to preclude a company from negotiating one agreement with one facility and a different agreement with another facility, or another carrier coming in and doing the same thing.

**Chairman Klein:** When BC/BS increased the amount of reimbursement for a hip replacement, they decreased the amount of reimbursement for a pneumonia stay which killed us in Carrington because we do a majority of pneumonia stays. My understanding was they did it for everyone and knowing that, it was just a matter of how we utilized and what we performed better in our facilities.

**Senator Potter:** Can you walk me through the rate increase process in regards to the 14.8%?

**Mike Fix:** The Rate Increase Request was filed on May 6th. The announcement of the provider withhold was towards the end of the same month, but I am not positive, and then...

3 people were jabbering and Senator Potter emerges and...

**Senator Potter:** How long does it take to process these rate increases, or to issue a ruling?

**Mike Fix:** What we try to do is to have the rate filing process completed in 60 days. It depend on what questions we have and how companies respond. Not just BC/BS, any and all

providers we are dealing with. If companies are not forthcoming to our questions, then we may just disapprove for lack of response.

**Senator Horne:** Does the Insurance Department feel it needs the authority granted in SB 2397 to have the authority to review rate case requests?

**Mike Fix:** No. Let me make it clear to the committee, with respect to the rate increase request, our position was that we cannot continue to review the rate increase request until the assumptions are validated. We are not able to validate the assumptions without the company not having the ability to unilaterally change what they are doing. We stand her in support of fair contracting standards. As far as the rate increasing process, we do have the authority to approve or disapprove rates. If we feel that a rate increase is not justified, the commissioner will preclude it.

**Chairman Klein:** You have read all 8 of the fair contracting principles/standards, do we need them?

**Mike Fix:** There is a tremendous amount of frustration amongst the providers with the contracting process. We here it over and over again. A bill that calls for fair contracting standards similar to what other states are using is a good thing.

**Senator Horne:** Are there other states that have fair contracting standards and if so, who are they?

**Mike Fix:** Minnesota and Colorado

**Chairman Klein:** recessed the hearing on SB 2397.

# 2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2397

Senate Industry, Business, and Labor Committee

☐ Check here for Conference Committee

Hearing Date: February 10, 2009

Recorder Job Number: 9089

Committee Clerk Signature Troy Schuchard

Minutes:

**Chairman Klein:** Called the committee back to order and asked for the opposition to SB 2397.

**Calvin Rolfson**, representing America's Health Insurance Plan, and I am testifying in opposition of SB 2397. (See attachment #1)

**Senator Nodland:** Are you saying, in a nutshell, the insurance commissioner has more than enough ample authority to handle any issue and also this bill, SB 2397 is not necessary?

**Calvin Rolfson**: To answer your first question, the answer is yes. To answer the second question, the Insurance Commissioner has ample authority that currently exists and its evident when it was exercised last year and apparently brought both sides to the table and changes were made.

**Senator Horne:** One of the main concerns was that BC/BS had issued an "across the board withhold", if we don't change the laws, how can this issue be addressed between parties involved?

**Calvin Rolfson**: I believe it can be addressed currently.

**Dan Ulmer:** Representing BC/BS of North Dakota, is testifying in opposition to SB 2397.

**Senator Horne:** How do you suggest we handle these "across the board withholding's"?

**Dan Ulmer:** It was resolved prior to going to the commissioner with the providers.

**Bob Stroup:** Deputy General Counsel for Noridian Mutual Insurance Company and BC/BS in North Dakota, testifying in opposition of SB 2397. (See attachment #2)

**Chairman Klein:** You have talked Colorado and Minnesota and the difficulties Minnesota has been having bringing other business into the state since they adopted this law. Can you tell us anything about Colorado?

**Bob Stroup:** I cannot. I can tell you Colorado designed their law based on a model from the American Medical Association in the late 1990's.

**Chairman Klein:** I thought the medical providers were driving this train and the insurance commissioner would be the regulator.

**Bob Stroup:** Two responses, first: it appears to me because of the lack of clarity in the statute, the fact it says "contracts have to be fair" and the Insurance Commissioner gets to decide that, it seems there is where the power is. There is too much uncertainty for us to be able to operate in the market because we don't know what fairness is. And the definition of "fairness" might change form Insurance Commissioner to Insurance Commissioner, or one contract to the next.

**Senator Horne:** Your contention is that the Insurance commissioner already has this authority to handle these issues and he shouldn't have more authority. And that the contracting process works and there are reasonable contracts that can be negotiated with BC/BS and the providers, and issues can be resolved without this committee recommending a Do Pass to SB 2397. Does that summarize where you are at?

**Bob Stroup:** Yes, the only statement that you made that I would disagree with is I am not so sure the commissioner HAS the authority and wondering if they need it. There is a whole title in the Century Code on Insurance, it lists what the commissioners duties are and governing

participation agreements with healthcare providers isn't listed there. There is also a statute that defines what the business of insurance is, and this does not seem to meet any of those definitions in North Dakota law. I am not sure if the law would permit him to have it in the first place.

Senator Potter: Let me see if I understand what you are saying, the commissioner lacks the authority but he doesn't need it because the providers stand for themselves.

**Bob Stroup:** That is exactly correct.

**Mike Potts:** the Assistant Vice President of Provider Networks, representing BC/BS of North Dakota, testified in opposition to SB 2397. (See attachment #3)

**Senator Horne:** It seems the underlying issue here revolves around payment to providers and how they are perceived by the providers to be not adequate enough. I think I heard you say one of the main problems regarding payments to providers is that Medicare and Medicaid are not paying an adequate amount. If those payments were increased, would that solve a lot of these problems?

**Mike Potts:** It certainly could, and we believe it would and we have been working with other representatives from other Blue plans in other states, at the Congressional level in Washington to try and improve reimbursement in rural and urban areas in both North Dakota and the surrounding states. There is a need for increased payments from commercial payers to make up the short fall. That is why we tend to be at the center of that discussion.

**Chairman Klein:** If I understand you, reimbursement for Medicare in New York City is different than Medicare reimbursement in Bismarck, North Dakota?

**Mike Potts:** Correct, reimbursement in New York City would be way higher than in Bismarck, North Dakota. The reason for that is a result of a complicated formula that takes into account the wages that are paid in the region as well as a number of other factors, so they formulate

into a formula that ends up in the fee schedule. We follow methodology that is somewhat similar to Medicare for our hospital inpatient as well as our physician payment methodology. What is different, we allow for the relativity in the Medicare system to be the same. We have a different conversion factor.

**Senator Andrist:** Do your payment schedules encompass the whole state or are their variables across the State as there are variables in Medicare across all the States?

**Mike Potts:** Yes, we have a uniform payment system.

**Chairman Klein:** we hear that BC/BS has a desire to close rural facilities, would go a long way into speeding that process up?

**Mike Potts:** It is unclear to me the ultimate results, we do believe it will raise costs. As we have and others have demonstrated, premiums in this state are among the lowest in the region. That is good for consumers. We don't anticipate having a negative impact on rural providers; however it must be a sustainable system.

**Senator Nodland:** You made arrangements with the Dickinson Hospital to help them out, is that correct?

**Mike Potts:** That is correct, we pay the rural outpatient part 25% more than what the 6 largest facilities receive, Bismarck, Fargo, Minot, and Grand Forks. We do that because of low volume and some other issues. In the case of Dickinson, we have a mid-tier rate as well, and that does include three other facilities in Jamestown, Williston, and Devils Lake.

**Pat Ward:** Representing Medco Health Solutions, testifying in opposition to SB 2397. (See attachment # 4)

**Jon Rice:** Chief Medical Officer at BC/BS of North Dakota, testified in opposition of SB 2397. (See attachment #5)

**Chairman Klein:** Are we the lowest in the region? Is our region high in comparison to other regions?

**Jon Rice:** Some of the lowest in the nation.

**Chairman Klein:** So when I am sitting in the coffee shop and someone makes their comment, I can say 44 other states have it worse. And not only do we have some of the best rates, we have some of the best coverage for the money we are paying.

**Jon Rice:** Yes

**Chairman Klein:** Closed the hearing on SB 2397

# 2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2397

Senate Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: February 11, 2009

Recorder Job Number: 9168

Committee Clerk Signature Erin Luckett

Minutes:

Chairman Klein: Bill 2397. The bill we heard yesterday.

Senator Potter: Moved to do not pass.

Senator Nodland: Seconded the motion.

Senator Andrist: For the record I thought it was the most confusing testimony we've heard on any bill yet. It was both parties, seemed to be more intent to throwing rocks instead of providing some daylight. I am going to support the motion to kill the bill.

Senator Behm: I agree the more they talked the more shot themselves in the foot.

Senator Potter: Along those lines there is an old saying I learned a long time ago, "The more you talk the more you lose". Of course I haven't learned that on the senate floor.

Roll Call Vote: Yes: 7 No: 0 Absent: 0

Floor Assignment: Senator Klein

Date: Feb 11, 2009
Roll Call Vote #: 1

**2009 SENATE STANDING COMMITTEE ROLL CALL VOTES**
**BILL/RESOLUTION NO.** 2397

Senate **Industry, Business and Labor** Committee

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Legislative Council Amendment Number

Action Taken ☐ **Pass** ☑ **Do Not Pass** ☐ **Amended**

Motion Made By Senator Potter Seconded By Senator Nodland

| Senator | Yes | No | Senator | Yes | No |
|---|---|---|---|---|---|
| Senator Jerry Klein - Chairman | ✓ | | Senator Arthur H. Behm | ✓ | |
| Senator Terry Wanzek – V.Chair | ✓ | | Senator Robert M. Horne | ✓ | |
| Senator John M. Andrist | ✓ | | Senator Tracy Potter | ✓ | |
| Senator George Nodland | ✓ | | | | |
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Total (Yes) 7 No 0

Absent 0

Floor Assignment Senator Klein

If the vote is on an amendment, briefly indicate intent:

## REPORT OF STANDING COMMITTEE

**SB 2397: Industry, Business and Labor Committee (Sen. Klein, Chairman)** recommends **DO NOT PASS** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2397 was placed on the Eleventh order on the calendar.

2009 TESTIMONY

SB 2397

#1

**Testimony SB No. 2397**
**Senate Industry, Business & Labor Committee**
**February 10, 2009**

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Chairman Klein and Committee Members. I'm Bruce Levi, and I represent the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for physicians, residents and medical students. NDMA strongly supports SB 2397, which would require that health insurance carriers engage in fair contracting practices with physicians, hospitals and other health care providers. The bill would clarify the authority of the Insurance Commissioner to review the contracts that insurance carriers execute with health care providers, identify a number of fair contracting standards that would apply to that review, and address enforcement of those fair contract standards. Before I explain the provisions in the bill, let me provide an overview of the problems this legislation is designed to address.

In past years, a number of states have developed "fair contracting" laws that afford physicians and other providers with protection in the contract process with insurance carriers. Colorado became the first state in 2007 to require insurance carriers to use uniform contract standards when negotiating with health care providers. Why the need for fair contracting standards? States recognize that most physicians face a true David and Goliath battle when negotiating contract terms with insurance carriers if, in fact, they are even able to negotiate these contracts. For example, BlueCross BlueShield of North Dakota (BCBSND) is able to exercise monopsony power with about 90% of the commercial health insurance business. Monopsony power is the ability of a small number of buyers (or a single buyer such as BCBSND) to lower the price paid for a good or service below the price that would prevail in a competitive market. In the health insurance industry, dominant health insurers like BCBSND are both sellers (of insurance to consumers) and buyers (of, for example, physicians and hospital services). As buyers of physician and hospital services, insurance carriers can lower the prices they pay to a point at

which physicians and hospitals may be forced to supply fewer services to the market.

BCBSND has historically been able to use its monopsony power, and present physicians and hospitals with take-it-or-leave it contracts. One implication of these annual "unilateral announcement of terms," is the inability of North Dakota health care providers to negotiate these terms. BCBSND pays for medical and hospital services at levels considerably less in North Dakota than by commercial insurers in other states in our region. At the request of NDMA, the six major health systems in North Dakota and BCBSND, the consulting firm *Milliman* prepared a report comparing health insurance premiums and provider reimbursement levels in North Dakota against other nearby states. *Milliman* was tasked with a comparison against other states in the Centers for Medicare and Medicaid (CMS) West North Central Region (Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska and South Dakota). In general, *Milliman* found that North Dakota has lower premiums, provider costs and provider reimbursement levels than the benchmark comparison states. The BCBSND Private Payer Hospital Reimbursement per RVU (geographically adjusted) is $66 compared to the rest of the region's average of $96, or only 69% of that compared to other states in the region. The Private Payer Physician Reimbursement as a percentage of Medicare (geographically adjusted) is 152% of Medicare compared to the rest of the region's average of 164%, or 93% of that compared to the rest of the region.

This is not simply a bill to address a hypothetical, future situation in North Dakota. Last spring, BCBSND attempted to take advantage of its adhesion contracts—which authorized it to unilaterally alter payment terms—by announcing an across-the-board "withhold" of payments. This was done, notwithstanding the objection of North Dakota physicians to BCBSND's decision to distribute a $26 million, one-time premium rebate in 2006, rather than holding those funds as requested by the medical community until the following year to address any volatility in utilization and to instead make premium and reimbursement adjustments in 2007. When utilization trends became an issue early last year, BCBSND attempted to shift its insurance risk to North Dakota providers by announcing the 2.5% payment withhold.

In July 2008, Insurance Commissioner Adam Hamm disapproved BCBSND's 14.8% premium rate request submitted for individual policies, largely because BCBSND had taken advantage of the adhesion contract, announcing the "across-the-board withhold." At the insistence of the

Insurance Department, new provider contracts were agreed upon for physicians and hospitals, incorporating some changes that result in fairer contracts, including changes that would not allow the insurance carrier to unilaterally withhold or reduce payments already agreed upon in the contract. Under the agreement between BCBSND and the Insurance Commissioner, the contracts must specify the manner of payment, the fee schedule, and methodology to calculate the fee schedule, and disclose of the effects of edits and fee schedule amendments. Nevertheless, BCBSND has asserted that the leverage the Commissioner asserted on this contract issue in the rate filing process is not appropriate, and that is one reason why SB 2397 is necessary to provide the Insurance Commissioner with appropriate authority to review and act on unfair contracts.

Now I'd like to walk you through SB 2397, which would incorporate into law this progress toward fair healthcare contracting.

**Section 1, Subsections 1 through 3: Fair Contract Enforcement**

Section 1, subsection 1, of the bill provides that all contracts entered into after January 1, 2010, must comply with fair contracting provisions enacted by the legislature, and invalidates provisions that conflict. These would include fair contracting standards created by SB 2397 as well as existing fair contracting standards already provided in statute. These include, but are not limited to, these existing statutes:

Interference with medical communications (NDCC 26.1-04-03(15)) - this prohibits "gag" clauses that restrict or discourage a physician from communicating to a patient information in furtherance of medically necessary care;

Unfair indemnification (NDCC 26.1-04-03(16)) – this prohibits contract clauses that unfairly shift legal liability to a health care provider;

Incentives to withhold medically necessary care (NDCC 26.1-04-03(17)) – this prohibits contract clauses that provide incentive plans that would induce a provider to deny, reduce, limit, or delay medically necessary care;

Retaliation for patient advocacy (NDCC 26.1-04-03(18)) – this prohibits a carrier from refusing to contract with a health care provider in retaliation for patient advocacy;

Unfair reimbursement (NDCC 26.1-04-03(19)) – this prohibits "most-favored nation" clauses that require health care providers to give the benefit of the lowest rate the physician negotiates with any other insurance carrier.

Section 1, subsection 2, of the bill requires the Insurance Commissioner to review contracts to ensure they conform to fair contracting standards, approve contracts that are fair, and enforce all fair contracting laws through fine and injunction. Subsection 3 provides definitions related to the first fair contracting standard relating to payment.

Section 2 of the bill would create a private cause of action for providers to remedy violations of any fair contracting standard.

The remainder of the bill identifies fair contracting standards.

**Section 1, Subsection 4: Disclosure of Fee Schedules, Payment Policies and Terms**
Would it not be fair to require insurance carriers to disclose payment terms and be held to those terms, as in any other reasonable contract?

Health care providers often do not have access to the fee schedules, payment policies and other payment rules developed by insurance carriers. The lack of uniformity in contracts due to differences in payment rules and procedures further aggravate the administrative burdens already placed on providers. Access to fee schedules and payment policies and terms is necessary for health care providers to decide whether a contract makes economic sense in the first instance, and also, after a contract is signed, to determine whether they are being paid correctly. Consistency in payment edits and rules across payers reduces the cost of auditing payments and enforcing payment accuracy.

Insurance carriers often unfairly reduce provider reimbursement through the use of "proprietary" code edits that are inconsistent with CPT® codes, guidelines and conventions, and through the practices of downcoding, bundling, and reassignment of CPT® codes. Multiple procedures are

sometimes "bundled" together and paid as a single procedure, or claims are "downcoded," meaning that they are submitted to the payer at one level of intensity but are reimbursed at a lower level reflecting a reduced intensity of service. Also, claims are sometimes simply "reassigned" to a different code. These practices unfairly reduce provider payment in ways that are difficult to identify, and for amounts that, while significant in the aggregate, are often too low to appeal on a claim-by-claim basis.

The first fair contracting principle provided by SB 2397 would require contracts between insurance carriers and health care providers to incorporate payment terms including any fee schedule or methodology used to calculate any fee schedule, incorporate edits that are consistent with CPT codes, and disclose downcoding and bundling edits.

**Section 1, Subsection 5: Contract Amendments**

Would it not be fair to require insurance carriers to provide reasonable notice of contract changes?

Contracts between health care providers and insurance carriers routinely authorize one party to the contract to unilaterally change the contract. When insurance carriers make a unilateral change to the contract or related policies and procedures, they do so without giving the provider prior notice of such amendments or allowing the provider a period of negotiation or time to terminate the contract. This unfair business practice reflects and further contributes to the inherent imbalance in negotiating power between health care providers and insurance carriers.

As a second fair contracting principle, SB 2397 would require that the provider be given 60 days notice and an opportunity to terminate the contract before a material change becomes effective, and that an insurance carrier not be allowed to unilaterally add, modify or delete material terms of the contract.

**Section 1, Subsection 6: Contract Termination**

Would it not be fair to require that written reasons be given by an insurance carrier for terminating a health care provider and that the carrier provide a reasonable review mechanism?

Provisions in insurance carrier contracts providing for termination "for cause" allow either party to end the relationship for certain clearly stated reasons in a specified time frame. These provisions are generally regarded as valid and necessary and, assuming they are bilateral, permit either party to terminate if the other party is not meeting basic contractual commitments. Unfortunately, these provisions are often not bilateral or reasonable. Termination "without cause" is the more controversial provision in contracts that typically allows either party to terminate the agreement without cause upon giving a certain number of days notice. If an insurance carrier exploits these provisions, the result can be the disruption of patient care and loss of a potentially significant patient base.

As a third fair contracting principle, SB 2397 would require an insurance carrier, prior to terminating a contract with a health care provider, to provide written reasons for the termination and provide a reasonable review mechanism, except under certain circumstances involving imminent harm to a patient's health.

**Section 1, Subsection 7: Credentialing**

Health care providers who are newly licensed or obtain new employment must complete and submit a credentialing application to be reviewed and approved by an insurance carrier in order for the provider to be considered in-network. In some states, particularly those with more competition in the health insurance industry than in North Dakota, the lack of uniformity in the credentialing process contributes to the length of the process during which time the insurance carrier often withholds payment from the physician. Furthermore, any undue delays in processing the paperwork could limit patients' access to health care services because the provider is not considered an in-network provider and payment may be retroactively denied.

Would it not be fair to require insurance carriers to request credentialing information in a uniform format that includes data commonly requested by insurance carriers for the purpose of credentialing, complete the credentialing process within 45 days and, immediately after a provider becomes credentialed, require the insurance carrier to retroactively compensate providers for services rendered from the date of their application?

As a fourth fair contracting principle, SB 2397 would require that credentialing information be requested in a uniform format, with a decision within 45 days of the completed application, with retroactive compensation from the date of the provider's application.

**Section 1, Subsection 8: Retrospective Denials**

A retrospective audit is one method used by insurance carriers to determine whether a provider has received an overpayment for services rendered. In such an audit, a carrier reviews claims paid to a provider over a certain amount of time – sometimes months and even years past. If the carrier determines that an overpayment has been made, it will look for repayment from the provider either by seeking a full sum reimbursement or by "offsetting" future payments (decreasing future reimbursements). While carriers benefit from these audits as a way to improve their financial bottom line, providers are faced with an administrative nightmare in trying to reconcile claims and maintain accurate financial records, not to mention the adequate cash flow necessary to keep their practices open.

Would it not be fair to require that retrospective payment denials be limited to a time certain?

As a fifth fair contracting principle, SB 2397 would not allow an insurance carrier to retroactively deny payment after the 6-month period from the date the claim was paid by the carrier, unless the claim is denied due to fraud. Such a retroactive denial would required to be justified in writing and if the claim results from coordination of benefits the written statement must provide the name and address of the entity acknowledging responsibility for the denied claim.

**Section 1, Subsection 9: All Products Clauses**

"All products" or "any products" clauses requiring health care providers to participate in less desirable product lines offered by an insurance carrier as a condition of participation or contract are particularly egregious in states where insurance carriers wield significant market power, as a provider has no choice in the matter. The provider community maintains an interest in seeing these types of clauses prohibited, or at least restricted in their application. Contracting relationships should be the result of a meeting of the minds after fair negotiation, not unfair dictates.

Would it not be fair to recognize that health care providers should be able to negotiate whether to provide medical services under a particular insurance product offered by an insurance carrier?

As a sixth fair contracting principle, SB 2397 would prohibit "any products" clauses that require providers participating in one product to participate in others.

**Section 1, Subsection 10: Rental Network Market**

Would it not be fair to prohibit insurance carrier from selling discounts they garner from a health care provider to other carriers without the provider's consent?

The rental network PPO market has evolved beyond the purpose of providing a provider network for a local, regional, national or increasingly international payer, into a lucrative secondary market in provider discounts characterized by a complete lack of transparency. This market has made it virtually impossible for providers to predict payments, trace claims, and/or challenge carrier determinations. It undermines the goal of transparency in health care because the provider cannot determine a patient's responsibility for payment at the time of service. In addition to adding to the already overwhelming administrative burdens placed on the physician practice, this activity deprives providers of fair payment.

As a seventh fair contracting principle, SB 2397 would preclude carriers from giving access to the provider's discounted rates to another entity, absent the provider's express consent.

**Section 3: Physician Profiling Programs**

Insurance carriers are increasingly developing profiling programs to evaluate the performance of physicians and other health care practitioners. A potential conflict of interest exists in these profiling programs because insurance carriers have a profit motive to steer patients away from high-quality providers that may cost more money or reduce the size of the provider network to limit access to care. To ensure that these programs do not undermine the patient- physician relationship, patients must be enabled to rely upon accurate and meaningful information on practitioner performance that include quality of care measures when making important health care decisions. Would it not be fair to ensure there are standards that apply to profiling programs?

As an eighth fair contracting principle, SB 2397 would place standards on profiling programs that are consistent with national agreements recently reached with seven of the top health insurance companies regarding their provider profiling programs. These agreements establish a process that seeks to guard against some of the risks inherent in these programs run by insurance carriers. SB 2397 would revise a current ND statute that incorporates profiling standards to ensure that rankings for physicians and other practitioners are not based solely on cost and use established national standards to measure quality and cost efficiency, including measures endorsed by the National Quality Forum (NQF); and provide a peer review appeal mechanism to resolve provider complaints.

Good public policies and principles support enactment of *comprehensive* fair contracting legislation that standardizes contract terms, requires adequate disclosure, and prohibits certain unfair contracting provisions. Passage of SB 2397 serves to enhance patient access to medically-necessary care. On behalf of the physicians of North Dakota, I urge you to recommend a "Do Pass" on SB 2397.

# SENATE BILL NO. 2397

**Presented by:** **Michael L. Fix**
**Director of the Life and Health Division and Actuary**
**North Dakota Insurance Department**

**Before:** **Senate Industry, Business and Labor Committee**
**Senator Jerry Klein, Chairman**

**Date:** **February 10, 2009**

Good morning, Chairman Klein and members of the Senate Industry, Business and Labor Committee. My name is Michael Fix, and I am the Director of the Life and Health Division and the Life and Health Actuary for the North Dakota Insurance Department.

I appear before you in support of Senate Bill No. 2397.

As you have heard in Mr. Levi's testimony, the Insurance Department has been involved in a contracting issue involving an announced withhold of provider reimbursements and its impact on recent rate increase requests by BCBS. Included in the documentation provided by the company requesting rate increases are assumptions regarding, among other things, the increase in the cost of benefits. An important piece of the increase in the cost of benefits is the increase in provider reimbursements, and this is one of the assumptions made to justify the need for a rate increase. It is in that regard that I offer my testimony.

Providers that called the Department after the withhold announcement were not aware that their contract allowed for a unilateral withhold of their payments, and were very concerned about the cash flow impact on their operations. They expressed frustration about their inability to have input into their contract and the contracting procedure.

It is for this reason that we support fair contracting standards and ask for a Do Pass on Senate Bill No. 2397.

I would be happy to answer any questions. Thank you.

**TESTIMONY**

**by**

**Calvin N. Rolfson**

**On behalf of**

**America's Health Insurance Plans**
**Before**
**Senate Industry, Business and Labor Committee**
**North Dakota Legislative Assembly**

**Regarding SB 2397**

**February 9, 2009**

**My name is Cal Rolfson. I represent America's Health Insurance Plans (AHIP). AHIP is a national association representing nearly 1,300 companies providing health insurance coverage to more than 200 million Americans. I appear before you today to oppose SB 2397.**

**There are many good reasons to be very cautious of this Bill. Here are some you may wish to consider – objections that address specifics of the Bill as well as its bad public policy.**

*** At page 2, line 18, regarding disclosure of payment rate information, there is no provision in the Bill for protections for confidentiality, fee schedules, proprietary methodologies, compensation, and the list goes on. To require disclosure of payment rates is to require disclosure of proprietary and therefore protected confidential information. Anti-trust state and federal protections and prohibitions apply that are not addressed in this Bill and perhaps cannot be overcome. The Bill simply provides no protections throughout its pages for confidentiality, provides no limitations on the use of such disclosed information and provides no penalties for violations of any requirements that apply to providers.**

*** At page 3, sub-division 8, there is a prohibition against retroactive denial after 6 months. What if an investigation by the insurer takes**

**longer than 6 months? What if the provider submits a material misrepresentation to the insurers in his or her billing that isn't discovered within 6 months. What if, after 6 months, the provider submits a bill for additional services rendered at the same time as the services for which payment has already been made?**

*** In Section 2 of the Bill, on page 4, why are the providers given a special private right to sue if a company fails to comply with the state's independent/external review requirement? So if a health carrier misses a deadline for submitting an external review by one day, it creates a private right of action by the provider? There already exists in the law a host of litigation options, including actions for breach of contract, injunctive relief, declaratory judgment and other causes of action that are currently available to <u>both</u> sides. There are plenty of common law and statutory rights now available to both parties.**

*** The Bill gives the insurance department the right to review the carrier's "fair contracting principles" – which is vague and undefined in the Bill. Why should the state step into the middle of a private party contract? Why is this needed when there is an explicit identification of what needs to be included in the contract? This open ended grant of undefined and vague authority to the insurance department is bad public policy. IF it remained, the carriers would, out of fairness, need protective confidentiality and indemnification provisions inserted into the Bill when the department seeks to make a company's proprietary data public, such as discount amounts.**

*** The Bill is lacking in necessary definitions. For example, though the term is used, I can find no definition of "health care product" in the Bill. The chapter of the Century Code this Bill amends (Chapter 26.1-04) does not define that term either. Also, there is again no definition of the term "fair contracting principles." The list goes on. The vagueness created by this Bill is significant.**

*** Going back to the top of page 3 of the Bill, there is a requirement to disclose "contractually agreed-upon bundling practices". Here carriers would be required to disclose to providers information that is used to monitor and identify fraud and irregular billing practices by providers.**

**Essentially, this Bill is a "fruit basket upset" for the present system of regulation and enforcement of insurance contracts. It may create years of common law and contractual law litigation to settle the issues created by the Bill. The Bill is simply not necessary. The Bill wrongly disrupts the arms length rights of private contracting parties. The Bill has no place in State public policy.**

**With the protections to both sides of this issue already available in current law and rules, we urge the Committee to simply say "NO" to this Bill.**

**Thank you for the honor of appearing before you.**

**Calvin N. Rolfson, for**
**America's Health Insurance Plans**

February-2009 Testimony SB2397

I'm Dan Ulmer, lobbyist #93 representing Blue Cross Blue Shield of North Dakota.

First off we'd like to remind this committee and the members of this legislature that BCBSND is a North Dakota Company owned by North Dakotans, managed by North Dakotans for North Dakotans...and that's probably one of the main reasons we have the market share that our present insurance commissioner and the sponsors of this bill seem to disdain.

Our membership is composed of over 400,000 North Dakota health care consumers and over the years we're taken pretty good care of our people as well as North Dakota's health care providers because this is our home too. For every premium dollar we collect we return over $.90 in health care services. Our reimbursement is around 160% of what Medicare pays and Medicaid pays around 40% of what we pay. Our premiums are some of the lowest in the country, the quality of North Dakota's health ranks with some of the highest in the nation and on behalf of our member/owners we vehemently oppose this bill . Make no mistake this bill is about money so if you don't think your constituents' health insurance premiums are high enough then you need to pass this bill.

The costs of today's health care are staggering; yet Research indicates that over 30% of health care is redundant, unnecessary, i.e.-wasted (that's $700 billion out $2.3 trillion/yr). A companion study showed that Americans only have a 55% chance of getting the most advisable care (see attached) and this bill will only exascerbate these numbers.

The general consensus around the country is that the insatiable costs of America's system have become unsustainable and the cost containment mechanisms under attack in this bill will significantly add to that problem by increasing costs. The gist of this bill eviscerates our right to private contracting and replaces it with political contracting by injecting the insurance commissioner squarely in the middle of adjudicating provider reimbursements. As our experts will attest, our reimbursements are based on medical efficacy not political whim. This bill fully injects political whim into the art of medicine by deferring contracting decisions that doctors and thousands of other health care professionals make today into the hands of an elected insurance commissioner/politician.

...and whether or not this leap occurs is in this legislature's hands and the first step will live or die within this committee...and I repeat we along with our members vehemently oppose this bill.

Mr Chairman Blue Cross presently pays out somewhere around $25,000,000/wk in health care claims to North Dakota providers and the gravity of this proposal has caused us to call in three of our experts who handle the issues contained in this bill every day. These folks along with hundreds of other professionals at BCBSND are the folks in the trenches of financing the day to day health care needs of our members who are also your constituents...once again we are a North Dakota company, owned and run by North Dakotans for North Dakotans.

We have the head of our medical management division- Dr. Jon Rice, the AVP of provider relations-Mike Potts, and our general counsel-Bob Stroup

Dr Jon Rice- a well respected family practitioner, former state health officer, and our medical director. Jon recently completed and is in the process of establishing at project called MediQhome. An initial pilot with Meritcare's diabetes patients- the pilot not only improved these patients' daily lives but saved about $500/patient in emergency room and hospital visits. It this savings can be replicated, it could mean an annual savings in care of the 50,000 BCBSND North Dakotans of $25 million. Anyone who's ever met Jon knows that his public policy credentials are impeccable and those of us who've had the privilege of working with him know him as a doctor's doctor.

Bob Stroup- As you can tell Bob played football for the Minnesota Gophers and I have found Bob's to be one of the brightest attorneys I've ever worked with in this field.

Mike Potts- Mike's job is to negotiate with providers, he and dozens of other people are in the trenches of this bill and I'm quite sure that you'll discover that Mike, like all of us at Blue Cross are more interested in providing high quality care to our members than we are in cheating providers out of their deserved reimbursements.

Mr Chairman---I would also suggest that this committee needs to decide whether or not this bill will require a fiscal note as the added administrative costs BCBSND will incur if this bill passes will directly affect our contract with PERS and we would therefore request that the committee take this into consideration during its deliberations.

In addition, although we have no standing in how the insurance commissioner would administer this bill it seems quite evident that the size of the additional tasks this bill imposes on the department has some fairly hefty fiscal implications in terms staffing.

Thank you for your consideration....
Dan Ulmer

# Executive Summary

The Blue Cross and Blue Shield System strongly believes that everyone in America should have health insurance. However, we are concerned that a healthcare system that is unaffordable for many today will not work for even more people tomorrow. We must make addressing both rising healthcare costs and extending coverage to everyone a national priority.

We know Americans without the benefit of health insurance get sicker and die sooner than those with coverage. We also know that rising healthcare costs – driven by an epidemic of chronic illness that accounts for 75 cents of every health dollar – have made coverage unaffordable for many.

But the problems only begin with the cost. We do not know enough about what works in medicine – and even when we do, the advice is often not followed. For the $2.3 trillion we spend annually on healthcare, we should expect more than a system where patients have only a 50-50 chance of getting the most advisable care and where 30 cents of every dollar may be spent on care that is ineffective, inappropriate or redundant.

We can get to tomorrow's coverage, but only if we attack the cost and change incentives to improve the quality of healthcare. With this report, the Blue Cross and Blue Shield Association (BCBSA) lays out detailed recommendations to improve the quality and value of our healthcare system, while simultaneously expanding access and coverage to all Americans. Achieving better healthcare quality and value and expanded coverage begins with America undertaking five initiatives:

**Improving Quality and Value**

1. **Encourage Research on What Works**
   America needs an independent institute to support research comparing the relative effectiveness of new and existing medical procedures, drugs, devices and biologics. We also must provide incentives to deliver safe, high-quality care.
2. **Change Incentives to Promote Better Care**
   The incentives in our system must be changed to advance the best possible care, instead of paying for more services that may be ineffective, redundant or even harmful.
3. **Empower Consumers and Providers**
   We must give consumers and providers the information and tools they need to make informed decisions. This starts with information systems to manage personal health records. In addition, consumers need to know how much they are paying and what they are getting for it.
4. **Promote Health and Wellness**
   We must promote healthy lifestyles to prevent chronic illness and work aggressively to help patients with chronic illnesses manage their own health.

**Expanding Coverage**

5. **Foster Public-Private Coverage Solutions**
   We need to tailor our coverage plans to capture the diversity of the uninsured population so that no one gets "squeezed out" by cost, "misses out" on available government assistance or "opts out" because they do not think they need coverage.

Clearly, there is no single answer for improving quality and value and expanding coverage. Meaningful change will depend on thoughtful, coordinated contributions from everyone – and it will require payers, patients, hospitals, physicians and policymakers to accept responsibility for taking part in the solution.

As leaders in the healthcare community for more than 75 years, the Blue Cross and Blue Shield System looks forward to working with all stakeholders to make quality healthcare affordable and accessible for all Americans.

**Testimony on Senate Bill Number 2397.**

**Chairman Klein, Vice Chairman Wanzek and Committee Members.**

I am Bob Stroup, Deputy General Counsel for Noridian Mutual Insurance Company, the Blue Cross Blue Shield plan in North Dakota, and I submit this statement in opposition of Senate Bill Number 2397.

I struggled with what to say to this group today that would not be tainted by the fact that I work for the largest health insurance company in North Dakota. For this trip, I brought my 11-year old daughter with me, Emily Stroup. Emily is the fifth generation of Stroup's to grace this noble building and see our state government at work. She is a 5th-grader and asked many questions along the drive from Fargo to Bismarck. She asked questions about the reasons I was going to appear here today, about the process involved, and most pointedly, what would happen if this bill was enacted into law. It was a long drive.

Also, whenever I am in the state capitol, I think of my grandfather and namesake, Robert L. Stroup, who served with this august body from 1966 through 1976, and who passed away in 2000. He was a Republican candidate for the United States senate in 1976, and many of his political views were passed on to me. He was a small business owner in Hazen, North Dakota, and esteemed philosophy that trumpeted the values of supporting business and industry, of letting the free-market system work without any "red tape" and the interference of government.

In reviewing this proposed bill, Senate Bill Number 2397, I imagine my Poppa Stroup turning in his grave. Through this bill, the legislature will change the health insurance landscape in North Dakota by extending unprecedented authority to a state government bureaucracy in favor of one private industry over another. This bills screams, "Red Tape and Big Government!" This bill screams, "Government Protectionism!" This bill hears not even a whisper from North Dakota business and individual consumer because the effect of the changes will not be passed down until after the passage of time. This bill extends governmental protections to multimillion dollar companies at the expense of North Dakota business owners and consumers. This bill is bad for North Dakota and for North Dakotans.

We oppose this bill because it interferes with the contracting process that currently exists in North Dakota between health care providers and third-party payors and insurance companies such as Blue Cross Blue Shield of North Dakota. The bill asks the legislature to give one group of private companies, doctors, clinics and hospitals an advantage in negotiating the terms of their contracts providing discounts on services over another private industry, insurance companies and third-party payors, adding unnecessary state-sanctioned contractual protections for these health care providers that will serve to only increase the costs of the health care coverage North Dakota companies provide to employees. This bill also extends unprecedented and unwarranted authority to the commissioner and insurance department to interfere in this contracting process, serving only to increase the costs of the health care coverage that North Dakota businesses provide to their employees. The passage of Senate Bill Number 2397 serves to create inconsistencies with current law and how health care coverage is provided to North Dakota business and their employees, increasing the costs of health care coverage by eliminating competition and the ability of insurance companies to negotiate discounts, and adding new levels of regulation and bureaucracy to a process where it never before existed. Moreover, this bill extends authority to the insurance commissioner to establish contracting terms with health care providers, including establishing the reimbursement levels traditionally left to private parties to negotiate, which will result in uniform reimbursement and inflexibility within the reimbursement

process. And Senate Bill Number 2397 does this all at the expense of North Dakota business and North Dakotans, forcing them to foot the bill for these unnecessary costs.

This bill interferes in the traditional contractual relationships governing the insurance industry in their interaction with health care providers by extending protections for health care providers related to the contracts they negotiate with insurance companies that will have a detrimental effect for not only employers, but employees and insurance consumers in North Dakota because it will drive up the costs of health care coverage and the delivery of services under insurance contracts. I have two colleagues appearing here today to address in detail the implications of enacting this legislation, but before they present these details to you, please allow me to address several of the drastic legal consequences included within this bill.

**Big Government and Added Bureaucracy**.

Enacting Senate Bill Number 2397 will cause a sea change in the costs of delivering health care services in North Dakota. These additional new costs will be imposed on North Dakota businesses and consumers through Senate Bill Number 2397 because of the unprecedented authority being extended to the commissioner of insurance and the insurance department. This is a puzzling approach for the regulator of the insurance industry in North Dakota to take, especially in light of his pledge to safeguard the interests of North Dakota consumers and deliver reasonable priced insurance products as his first priority. Make no mistake about it, Senate Bill Number 2397 adds new and restrictive government bureaucracy in place where none existed before, and these added requirements will result in higher costs to North Dakota businesses and consumers.

*The Grant of Authority to the Commissioner of Insurance Is Broad and Ambiguous.*

Initially, Section 1 of this bill extends authority to the commissioner of insurance to "review each contract to ensure conformity with fair contracting principles;" to "approve contracts that comply with fair contracting laws," and to enforce contracting laws through fines and injunction." In Section 2, the bill also extends enforcement authority to the commissioner over the new contracting requirements, along with numerous other provisions in the insurance code. Before addressing the unprecedented extension of authority to the commissioner extended in Senate Bill Number 2397, please note that the bill currently leaves certain terms undefined, which terms are so ambiguous and amorphous so as to have no reasonable meaning at all.

The commissioner initially has the authority to ensure conformity with "fair contracting principles." However, "fair contracting principles" remains undefined in the proposed legislation, nor is it defined anywhere else under North Dakota law. This provision alone provides the insurance commissioner with the unrestricted authority to mandate any contract language that the commissioner deems "fair," without any guidance or limitation, into agreements that have in some circumstances been in existence for over 40 years, without any previous ability to do so. Similarly, the bill requires that these contracts must be approved by the commissioner only if the contracts comply with "fair contracting laws" thereby subjecting any entity that disagrees with the commissioner a prolonged and costly administrative review process. What is "fair"? Where are the "fair contracting laws"? Who makes this determination? It appears that all of these considerations are left to the unbridled discretion of the insurance commissioner. This will create not only a landscape of unprecedented administration of contracts and contract terms by the insurance department where none before existed, but will create uncertainty in what was determined to be "fair" in one context or contract but "unfair" in the next. I

have searched the North Dakota Century Code for any similar broad grant of authority for an administrative agency to extend authority over private contract terms, but have been unable to uncover anything even close. These provisions are too broad, grant the insurance commissioner too much discretion and do not establish any viable or recognizable standard upon which health care providers or insurance companies may operate. How will any insurance company understand the contractual requirements that are being imposed upon them when the standard is "fairness" and the final arbiter is the insurance commissioner with no other directive than the discretion of his office? This basically results in no discernable standard at all.

These ambiguities will lead to uncertainty in the relationship between insurance companies and health care providers, including delays in getting these agreements reviewed and implemented, caused by the added layers of government intervention, and these delays will lead to higher costs for North Dakota employers and insurance consumers.

*Grant of Authority is Unprecedented and Costly.*

In addition to the unreasonable ambiguity and untenable discretion extended to the insurance commissioner to interpret "fairness" included in Senate Bill Number 2397, there is the unprecedented grant of authority in the insurance commissioner over matters previously left to private entities to contract in a capitalistic economic system. Currently, the insurance commissioner has exceedingly limited authority to review the contracts between insurance companies and health care providers. There are several provisions limiting insurers from including certain contractual provisions in their agreements with health care providers that are aimed at protecting the insurance consumer from placing certain restrictions on providers in dealing with their patients and the costs of services by making these prohibited practices. Along with these few limitations, there is a provision permitting the insurance department the ability to review contracts between insurance companies and health care providers to comply with the preferred provider statutes enacted in 1987. However, both of these statutory grants of authority to the insurance commissioner are limited in scope and aimed at protecting the insured and the employees of North Dakota businesses. Senate Bill Number 2397 is aimed at only protecting the interests of large health care providers at the expense of North Dakota businesses and consumer.

Finally, it appears as though Senate Bill Number 2397 includes the requirement that all current agreements existing between insurance companies and health care providers must all be brought into conformity by January 1, 2010; that all such agreements in place must be amended and provided to the health care provider whenever there is a "material change," and that any such material changes be communicated to the health care provider in advance and become a pert of the contract. Setting aside the questionable authority to amend and terminate provider contracts that are already in place (some for decades), this will result in an unprecedented and costly process of having to replace all the provider contracts that the insurance commissioner determines are "unfair" by the end of this year. The bill will also require that any contract in place be replaced whenever there is an amendment the insurance commissioner deems "fair" but also to be a "material change." Finally, the requirement to deliver all future amendments will eventually result in a provider contract that nears the size of the New York City white pages in pretty short order. All of these requirements will result in the need to print, mail, and pay for paper and postage, and necessitate added administrative functions and costs, for thousands of currently-existing provider contracts. While Blue Cross Blue Shield of North Dakota struggled to assign actual costs to the different components to this bill but was unable to because of the ambiguity and uncertainty inherent in the proposed legislation, even I am able to do the math on this

aspect of the bill. All of this appears to be unnecessary and added costs aimed at granting new autonomy to the insurance commissioner where heretofore none ever existed.

What is the reason for this current extension of authority and enhanced regulation?

*Increase Competition.*

The commissioner apparently believes that extending authority over these private business contracts and increasing regulation of the insurance industry will increase competition in North Dakota by increasing the number of insurance companies interested in doing business here. This extension of authority by state government over what has traditionally involved a contracting process between private companies does not send the right message to potential companies looking to enter the insurance market place in North Dakota. More and more regulation of the insurance industry leads to less and less competition. Just look at the market in Minnesota, where there is high regulation. There have not been any new viable companies entering its health insurance market in almost 20 years.

Similarly, extending additional authority to state bureaucracy sends the wrong message to other potential industry and companies looking toward North Dakota because it imposes the costs of these new regulations to North Dakota businesses to pay for them.

This added authority and regulation will also result in the insurance commissioner establishing payment and reimbursement levels in the market, eliminating differentials between health care providers and the possibility of limiting or reducing reimbursement levels for health care providers in North Dakota. This differential has a potentially draconian impact on different types of health care providers (e.g., medical doctors over advanced practice registered nurses or chiropractors), or the location of providers (e.g., an institutional provider located in a rural community over one in a more urban setting). The health care providers may regret what they wished for should Senate Bill Number 2397 be enacted into law.

*Protect the Provider Community from Insurance Companies.*

The bill extends authority to the insurance commissioner and insurance department over the private right to contract that has traditionally existed between insurance companies and doctors, clinics and hospitals. This arrangement does not seem to involve or implicate the insurance industry at all. Senate Bill Number 2397 protects health care providers by extending to the commissioner the authority to review all contract terms, the power to level fines and injunction for matters of private contract, and authority to approve the agreements based on an ambiguous and amorphous standard. This regulatory authority will only serve to increase administrative costs through more government, more red tape, and more bureaucracy. It is difficult to understand how such regulatory authority and its added costs that get passed down to North Dakota businesses and their employees, furthers the commissioner's primary responsibility to the North Dakota insurance consumer. Do these health care providers really need this governmental grant of protection? How does this bill, adding more layers of regulation to a currently unregulated aspect of this industry, further the cause of the insurance consumer? In fact, it does exactly the opposite, it increases the costs to North Dakota business and individual consumer through the interest in "big government" and extending bureaucracy in protecting private industry, like the providers, clinics and hospitals that they believe they are being protected by this bill. This should not be allowed.

And the new authority granted to the commissioner and insurance department will not only add administrative costs that are passed down to North Dakota businesses and their employees, but this bill includes provisions that will directly add to the costs of the health care services and benefits that must be provided and paid for. Senate Bill Number 2397 grants to the commissioner the authority to review each contract to ensure conformity with fair contracting principles, and then sets forth several, but not all, of these fair contracting principles. One of these principles limits the ability of insurance companies to adjust the payments made to health care providers for services that may have been paid improperly. These are direct costs for the payment of improperly rendered services that get passed on to North Dakota businesses. Similarly, the bill limits the ability of an insurance company to correct payment terms that are incorrect or impose changes in these contracts by requiring the insurance company to continue making the improper or inaccurate payment to a health care provider until after notice is provided and a new contract is forwarded to the provider. North Dakota businesses will pay for this regulation. All of this new authority granted to the commissioner will result in additional health plan costs that are passed on and must be paid for by North Dakota businesses.

**Protecting Private Industry.**

Senate Bill Number 2397 extends legislative protections to private business entities by mandating certain contractual terms aimed at protecting these private businesses where there existed no protections before.

Are these protections needed? The message the health care provider trade associations, their lobbyists, want you to hear is that health care providers are at the whim and caprice of the insurance companies in North Dakota, primarily Blue Cross Blue Shield of North Dakota. The describe themselves as the 98-pound weakling on the health care beach, arguing that Blue Cross Blue Shield of North Dakota never wastes an opportunity to kick sand in their faces. As a result, these health care providers have been lured into supporting Senate Bill Number 2397 by the "protection" offered by the insurance commissioner and through several contractual provisions required in contracts that previously were left to private business entities to negotiate. What is the reality?

In the first place, these are not 98-pound weaklings but multi-million dollar businesses with the resources and expertise to stand on their own and negotiate with private industry. Altru Health Systems total patient revenue in 2007 was $642,229,146 million dollars, MeritCare Health System for the same year was $599,088,047 million dollars, St. Alexis had revenue of $353,704,251. In the smaller communities, Dickinson had total patient revenues of $70,839,337 million dollars. 98-pound weaklings indeed. All tolled, the total patent revenues for institutional providers in North Dakota for 2007 equaled nearly half a billion dollars. And this does not even account for the private clinics and other health care providers in the market. Do these private companies really need protection either from extending added regulatory authority to the insurance commissioner or through imposing contract terms on their arm's length agreements negotiated with insurance companies? I wonder what your reaction will be when they request similar "protection" against the bed-pan industry because they are dissatisfied with the prices they are able to negotiate. Where will this stop? Make no mistake, these health care providers are large, sophisticated businesses with the resources, authority and knowledge to take care of themselves. These health care providers do not need the legislature, or the insurance commissioner, to tilt the playing field their way.

Similarly, the health care industry trade associations seem to imply that the current provider agreement process in place, at least with Blue Cross Blue Shield of North Dakota, leads to unilateral contracts or

adhesionary contracts. That Blue Cross Blue Shield of North Dakota has a "take it or leave it" philosophy when it comes to negotiating these agreements. Nothing could be further from the truth. Initially, please note that the terms of the contracts in place seldom, if ever, result in any disputes between health care providers and Blue Cross Blue Shield of North Dakota. If you are a health care provider with a contract with Blue Cross Blue Shield of North Dakota and you entered into this contract in the 1970s or before, your entire agreement was printed on a three-inch by five-inch card. In the 1980s, the size of the base contract grew to five-and-one-half inch by eight-and-one-have-inch contracts. The current base agreements are usually not much longer than two or three pages. In the handful of matters that escalated to involving the need for the Legal Department since I joined Blue Cross Blue Shield of North Dakota in 1997, the first thing always requested by the health care provider or their legal counsel was a copy of their provider agreement with North Dakota, usually because they could no longer locate their copy. The agreements are sent out to the providers *pro forma*, signed by the provider and returned to Blue Cross Blue Shield of North Dakota without so much as a question or concerns received.

However, admittedly, in the more complicated managed care world, there are multi-page provider contracts utilized. These agreements, particularly the attachments, are subjected to prolonged negotiation between the health care providers and Blue Cross Blue Shield of North Dakota. And Blue Cross Blue Shield of North Dakota does negotiate these terms. In fact, I am currently in the middle of negotiating a change in a long-standing contract provision at the request of the health care provider. Does this process really seem as though it requires the intervention of the legislature to "fix" things and protect the health care providers, or necessitate added regulation and interference by the insurance commissioner?

And to what end? The current provider contracting process allows Blue Cross Blue Shield of North Dakota to offer the lowest premium for a comprehensive health insurance plan than any other state in the region. The current process benefits North Dakota businesses and individual consumers by limiting the costs of their health insurance. Senate Bill Number 2397 will directly lead to increased costs.

As my colleagues will point out, this bill includes specific provisions that will directly impact this traditionally private industry contractual arrangement by adding administrative costs for contracting with health care providers that will be passed on the to businesses buying insurance, their employees and individual consumers. The bill requires specific contractual terms and that these new contracts all be reissued to health care providers or allow the providers to terminate these contracts. There is a clear cost to businesses in doing this just in paper and postage alone.

There are similar administrative requirements in the bill that will increase costs not only in regard to reissuing contracts, but in the filing requirements included in the bill (specific information related to the payment terms of the contracts), through limitations in the terms that can be included in these contracts (limits on reimbursement and medical management), and through limitations on processes currently in place that result in better quality of care and savings for North Dakota businesses (limits on credentialing and provider profiling). The addition of "red tape" to the contracting process and restrictions on quality initiatives and cost management processes will all be costs that are passed on to North Dakota businesses.

A few examples of these aspects of Senate Bill Number 2397 will illustrate. One provision of the bill limits the ability of an insurance company to adjust a claim at any time once six months has transpired

from the date the claim was paid. This will result in insurance companies paying claims for services not properly rendered or that were not covered under the health plan but paid because billed incorrectly by the provider. In many instances, Blue Cross Blue Shield is unable to even identify these situations within the established sixth-month timeframe. As a result, a provider who submits an improper claim but gets paid by Blue Cross Blue Shield of North Dakota in February may retain this payment after in July no matter the reason that the payment was determined to be incorrect. These costs are passed on to the group through the underwriting process and the health care provider is allowed to retain payments that it is not entitled to. Further, in the case of some health care benefits, this provision will cheat the individual insured from benefits to which they are entitled under the health plan. For example, say a health care provider bills Blue Cross Blue Shield of North Dakota for 50 in-patient mental health stays, and gets reimbursed for these days. Thereafter, 180 days later, Blue Cross Blue Shield learns that the health care provider incorrectly billed for these services and the member really only received 35 in-patient days. The patient is entitled to 50 days under state law but only received 35, who pays for these other days? Why should the health care provider benefit from this situation at the expense of the insured? The federal government is permitted to take these readjustments at any time for Medicare claims improperly paid, certainly a private insurance company is entitled to the same contractual rights. These are only a few illustrations of the potential impact of Senate Bill Number 2397.

Finally, the proposed bill even extends a private right to doctors, clinics and hospitals to sue insurance companies and third-party payors. Health care providers presently always could pursue a breach of contract claim against an insurance company like Blue Cross Blue Shield of North Dakota if the provider felt a violation of the contract occurred. Senate Bill Number 2397 includes a separate legal claim solely for violating the statute that is apart from the breach of contract claim. These potential litigation costs will increase administrative expenses for insurance companies and by necessity get passed on to North Dakota businesses, their employees and individual consumers.

**Confusion Caused by Interference with Terms of Current Agreements.**

Senate Bill Number 2397 will also lead to confusion and uncertainty in the administration of health care services in North Dakota at many levels because it will create confusion related to health plans that are sponsored and paid for by employer groups and those plans with current contracts already in place.

There are currently two ways in which health plans offering health benefits to employees are funded by employers in North Dakota. The employer can purchase insured coverage from and insurance company offering dental coverage, or the employer can sponsor its own, self-funded health plan with dental services included.

A self-funded health plan has enhanced protection under federal law that exempts them from having to follow the requirements of state laws, such as that created by Senate Bill Number 2397. The effect of this exemption will create two differing provider contracting systems in North Dakota based on the type of health plan the patient received services under. If the patient received health care services under a self-funded, employer sponsored health plan, these contracting statutes will not apply to their employees.

However, with a patient receiving health care services under an insurance plan, the statute may apply and require an insurer to have different agreements in place with health care providers that apply these different terms.

This will result in frustration and confusion for not only to providers caused by differing contract terms, but also for businesses and patients, who will receive not only different services and benefits based on the type of health plan covering their benefits, but in the quality of these benefits. This aspect of the effects of Senate Bill Number 2397 may even impact businesses having to offer different plans to their employees, some employees covered under a self-funded health plan with one set of provider contracts in place and other employees covered under a fully insured plan with contracts governed by this legislation. In this instance, this company's employees may receive different benefits and coverage.

In attempting to explain the reasons that I appear here to Emily, my eleven-year old daughter, I tried to keep this exceptionally complicated legislation as simple as possible. I advised her that the law was an attempt to change the current way companies, like Blue Cross Blue Shield of North Dakota, do business in North Dakota through the legislature giving added protections to other private companies that did not really seem to need this protection. I also explained to her that through this law, the legislature was granting power to an administrative agency that had never had it before, authority the agency did not really seem to need, and at the expense of our customers and counter to the agency's responsibility to individuals in North Dakota. I think my grandfather would have liked that answer.

For all of these foregoing reasons, I respectfully request a DO NOT PASS on Senate Bill Number 2397.

**Testimony on SB 2397**
**Industry Business and Labor Committee**
**February 10, 2009**

Chairman Klein and members of the Industry Business and Labor Committee, my name is Mike Potts and I represent Blue Cross Blue Shield of North Dakota. I am the Assistant Vice President of Provider Networks and have overseen provider relations and contracting activities for the past 12 years.

I am here to discuss the impact of Senate Bill 2397 on policy holders, participating providers and payers. Before I do that I would like to give you some perspective on healthcare finance issues in North Dakota and some background on how Blue Cross Blue Shield of North Dakota manages its participating provider relationships and contracts.

Blue Cross Blue Shield has a contractual relationship with each provider who completes an application and meets eligibility and credentialing requirements. Successful relationships between providers and insurers are a cornerstone in a long-term, sustainable healthcare system. In order to create a sustainable system, insurance premiums must be adequate to cover administration, claims costs and reserve needs. The overall provider reimbursement from all payers must also be adequate to cover provider actual costs and reserve needs.

North Dakota providers have experienced significant financial challenges in recent years with low payments from Medicare and Medicaid. This phenomenon forces providers to look for increased reimbursement from commercial insurers to make up the shortfall. Their fiscal bottom lines are under considerable strain and it is clear that changes are needed. A recent Milliman study commissioned by the North Dakota Medical Association and paid for by the six largest North Dakota provider organizations and Blue Cross Blue Shield of North Dakota yielded some interesting but not surprising results. Four key North Dakota measures were compared to those of surrounding states: Iowa, Kansas, Minnesota, Missouri, Nebraska, Montana and South Dakota. The results showed that North Dakota premiums, provider reimbursements, hospital costs and hospital operating margins were all lower than the comparison states. In addition to this study, you should know that Blue

Cross Blue Shield of North Dakota administrative expenses were less than 8% of premiums in 2007 and continue to be among the lowest in the Blues' system. This is good news for employer groups and consumers as it indicates they are getting good value for their premiums.

Relating to government payer shortfalls, however, another study conducted by Milliman in December of 2008 showed that nationwide, 15% of total commercial costs for hospital and physician claims are the result of government payers not paying enough. The study goes on to state that a typical family of four under a commercial insurance plan absorbs an extra $1,788 annually in additional premium and out of pocket expenses due to government payer cost-shifting. These pressures on providers are exacerbated by stagnant population growth and a large number of services going out of state. Commercial insurance members pay for these shortfalls.

Despite this discouraging financial landscape, the North Dakota provider community continues to deliver some of the best quality healthcare in the United States. North Dakota was ranked the 13th healthiest state in a June, 2007 study conducted by the Commonwealth Fund. The Medical Group Management Association recently conducted a provider satisfaction survey and Blue Cross Blue Shield of North Dakota was ranked 20th out of approximately 250 health plans for overall provider satisfaction. There have been no hospital closures in over a decade and there was a net addition of 33 physicians and 106 other professionals to Blue Cross Blue Shield's Par network in 2008 compared to 2007.

These are the factors and the real problems in North Dakota healthcare that lead up to this important discussion on provider agreements. I respectively ask this committee to carefully consider the impact of this bill and whether it will help solve these foundational problems or create additional unnecessary and unproductive bureaucracy. I will now provide some background on Blue Cross Blue Shield of North Dakota's provider contracts.

The participating provider agreement defines basic components of the business relationship and how business operations will be conducted between the parties. I have

submitted examples of key payment provisions from the Participating Physician and Participating Institutional agreements recently approved by the North Dakota Department of Insurance. These contracts are reviewed and approved by the Department of Insurance. The Department has advised us the agreements are reviewed against the PPO (ND Century Code 26.1-47) and other applicable regulations to ensure the company meets all requirements. Coding, billing, administrative and payment policies, reimbursement rates and medical policies are proprietary and are not part of this review and approval process.

The current agreements define the basic relationship between insurer and provider but do not define all details. The additional details are communicated to providers through other routine notifications. Blue Cross Blue Shield notifies providers annually of payment methodology and changes to individual payment rates through a reimbursement notice.

I provided you with a sample copy of the 2009 Institutional and Professional Reimbursement Notices mailed to providers prior to the January 1, 2009 effective date of the payment system changes. The Institutional Reimbursement Notice is sent to hospitals with at least 60 days notice as defined in the Institutional Agreement, 2.1.b. The Professional Reimbursement Notice is sent in December in compliance with the 5-day notice provision within the Physician Agreements, 2.1.b. Each of these notices includes a CD with all of the codes and rates so providers can conduct analysis and forecasting based on their own mix of services.

In addition, the January 2009 issue of the monthly Health Care News is provided for your review and shows the follow up to the Reimbursement Notices including a summary of changes to the payment system for 2009. This bulletin and subsequent issues defines specific coding, billing, administrative, payment and medical policies as well as definitions, descriptions and clarifications of existing policy and procedures. Updates are made throughout the year as new medical technologies, drugs and codes become available. Reimbursement methodology and rates can only be updated once per year as defined in section 2.1.b in the agreements with exceptions also defined in the same section. Health Care News is sent to participating providers through the United States Postal Service and

is also available through the public section of THORconnect.org which is Blue Cross Blue Shield of North Dakota's Internet website for providers. Providers can also access all individual fees through the website.

Blue Cross Blue Shield of North Dakota works hard to be transparent and make each of these documents available to providers. The documents and the processes I have described illustrate the complexity, detail and constant maintenance involved in managing a contractual relationship between an insurance company and a participating provider. The process must be conducted in a timely manner and on a regular basis to ensure that all policies, rates and procedures are up to date. Blue Cross Blue Shield of North Dakota has dozens of staff from several departments and disciplines working full-time to manage these processes and relationships.

As I discuss this bill it is important to recognize that what appears to be subtle differences between the current Department of Insurance authority and approval processes that I just described and those defined within this bill are in reality quite substantial. Under this bill, the Department of Insurance authority would be greatly expanded to include the review and approval not only of contract language but also of coding, billing, administrative and payment policies, reimbursement rates and medical policies. All changes defined as material changes would be subject to review and approval by the Department of Insurance.

According to the bill in lines 11-15 on page 2, "'material change' means a change to a contract which decreases the healthcare provider's payment or compensation for medical services or reimbursement for medical goods or which changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense." In addition on page 3 lines 7-11 it states, "The contract may not allow the entity to add, modify, or delete material terms of the contract without the consent of the health care provider, including the scope of medical management, the amount and manner of payment, and other terms of the contract determined by the commissioner to be material terms."

This "material change" provision is very concerning to Blue Cross Blue Shield of North Dakota as it could jeopardize our ability to set reasonable payment rates, it will also eliminate our ability to introduce reasonable cost-containment measures to safeguard our customer's finances and it may also delay adjudication of claims. Reimbursement rates are adjusted annually and the formulas for setting rates specify some codes to increase and others to decrease even though the net effect is an overall increase as specified in the reimbursement notice. Is the intent of this bill to eliminate any negative adjustments to annual fee schedules even if the company uses a recognized and reasonable formula? Does this also mean the Commissioner is responsible to determine medical necessity or if medical policies are appropriate in relation to material change? Also, insurers are required to process clean claims in 14 days. If a new code is added during the year will the company have to wait for the commissioner to review and approve the rate for that code and can it be done timely to ensure the claim can be paid within 14 days?

The provision does not specify the level of dollars or percentage change. Would a $10 or $10,000 change both be considered material and require the review and approval of the Insurance Commissioner? Also, since the member's benefits can have an impact on provider payments will these be subject to additional review as well? The most recent approvals of the physician and institution participation agreements took over 75 days to complete.

These provisions appear to make the Department of Insurance responsible to only approve raises to reimbursement rates to providers and to presumably improve their financial condition. Is this the intent of the bill and is the Department of Insurance prepared to take on this role for North Dakota given the financial issues I described earlier? If this is to be the new role for the Department of Insurance, should there not also be a requirement to approve required funding and premiums to support these increases?

The process would require routine updates of the entire agreement as well. The Department would need to hire additional staff with the necessary training and expertise in coding, reimbursement and medical policy at a time when there is a shortage of these

experts in the region. Also, given the large numbers of code and service combinations, it would be challenging to review and approve this level of detail in a timely manner for all insurance companies doing business in North Dakota.

Approval delays could also lead to delays in notifying groups and individuals of new premium rates. This would be particularly problematic leading up to January as most of Blue Cross Blue Shield of North Dakota's groups and provider agreements renew at that time. Is the Department of Insurance prepared to hire staff with this type of expertise to track, analyze and approve all these requests?

This requirement would also place additional burden on providers as they would need to sign off on each new agreement and would have to search the newly amended and all past agreements, for coding, billing and payment policies to ensure they apply the most appropriate policy to the service being billed. Today, providers can search for individual topics in Health Care News or on THORconnect.org without searching through prior and current agreements.

Blue Cross Blue Shield of North Dakota already provides payment system updates in a timely manner as defined in existing agreements. As mentioned, section B of the Institutional and Physician Agreements specifies that "...changes to the BCBSND payment system as set forth in the Reimbursement Notice shall be permitted only once every calendar year and no payment withholds may be imposed." This language was agreed to by the company and recently approved by the Department of Insurance after months of discussion and debate.

I also have concerns with the provisions related to credentialing, retroactive denials, and network rental. The company has a single uniform application process already and is working with many providers to improve credentialing by delegating to their internal programs. Credentialing includes verifying that a provider's education, licensure, certifications and malpractice histories are all within policy guidelines. The BCSBND effective date is the provider's hire date and it is unclear if this is the same as application date.

Regarding refunds for retroactive denials, the company is streamlining the provider payment listing process through the use of better online systems. The company has a fiduciary responsibility to employer groups to ensure that claims are administered in accordance with the member's benefit plans. If providers are overpaid, the member's coinsurance will be too high. Manual processing of written notification will require additional paperwork for providers and, there is no provision in the bill as to how soon or if providers must respond or agree to such written notices. In 2008, the company requested over 30,000 refunds from providers. In addition, recoupment of claim refunds from future payments is standard practice for Medicare. I presume this process will significantly increase provider administrative expense therefore, would it not be considered a material change and thus should be prohibited?

Regarding network rentals, the bill does not specify whether the BlueCard Program is considered a rental. The BlueCard program is a requirement of the Blue Cross Blue Shield Association that allows Blue Cross Blue Shield members from other states to access the North Dakota provider network and discounts. If this bill does pertain to BlueCard, the company is highly opposed as passage of this language would jeopardize Blue Cross Blue Shield of North Dakota's license and symbols and members would be subject to additional high charges.

Chairman Klein and committee members, there are many more things to discuss on this bill but let me finish by saying I do not believe this bill will improve providers' overall understanding of their obligations under the participation agreements nor will it contribute toward long-term healthcare system sustainability. Instead it will create an environment where every agreement change or provider concern related to that change must be funneled through a costly review and approval mechanism at the North Dakota Department of Insurance. This will slow down forward progress and harm members. I believe the best hope for a long-term, sustainable healthcare system in North Dakota is for providers and payers to work together to solve their problems and create solutions for members under a reasonable regulatory environment.

The Department of Insurance has stated a desire to see increased health insurance competition. Passage of this bill may have the opposite effect as some insurers discontinue doing business in the state. In addition the Blue Cross Blue Shield fee schedule could become the benchmark for other insurers if it becomes public information with the result being reduced payments to providers. I urge this committee to thoroughly study this issue before assuming increased regulation and Department of Insurance oversight will increase competition and yield productive and enduring solutions to these long-term problems.

I respectively request a Do Not Pass on SB 2397. I would be willing to answer any questions the committee may have.

**Reimbursement Provision from BCBSND Institutional Participation Agreement**

BCBSND shall:

2.1 A. Reimburse the Provider for Covered Services based on the BCBSND payment system in effect at the time the services are rendered, excluding Cost Sharing Amounts, and as set forth in the BCBSND Institutional Reimbursement Notice. The Reimbursement Notice is composed of separate schedules and information which fully identify the BCBSND payment system. The total compensation set forth in the Reimbursement Notice includes information sufficient for the Provider to determine the compensation for services and procedures rendered pursuant to the provision of Covered Services, including:

1. The manner of payment, such as fee-for-service, capitation, or risk sharing;

2. The fee schedule for services reasonably expected to be billed by the Provider for services provided pursuant to this Agreement. BCBSND shall provide, upon request, the fee schedule for any other services reasonably expected to be billed by the Provider. BCBSND shall make available a fee schedule for the services when a material change occurs. A Provider who receives fee schedule information may only use or disclose the information for the purpose of practice management, billing activities, and other business operations; and

3. The methodology used for any fee schedule, such as relative value unit system and conversion factor, percentage of Medicare payment system, or percentage of billed charges. As applicable, the methodology disclosure shall include the name of any relative value system, its version, edition, or publication date, and any applicable conversion or geographic factor. BCBSND shall state the material effects of edits, if any, on payment or compensation.

   Upon request, BCBSND shall provide a description and copy of the coding guidelines, including any underlying bundling, or other payment process applicable to specific services under the Agreement. A Provider may only use or disclose the information for the purpose of practice management, billing activities, and other business operations.

B. Except as provided below, changes to the BCBSND payment system as set forth in the Reimbursement Notice shall be permitted only once every calendar year and no payment withholds may be imposed. Notice of such annual changes shall be sent to the Provider at least 60 (sixty) days prior to the effective date of the annual changes.

The Provider specifically acknowledges and agrees that the limit on annual changes to the BCBSND payment system imposed under this provision shall not apply to adjustments or modifications imposed exclusively as a result of any of the following: (i) quarterly pharmacy/injectable drug adjustments, medical supplies and other goods; (ii) scheduled coding changes for CPT®/HCPCS codes; (iii) adjustments or modifications made by the Centers for Medicare and Medicaid Services (CMS); (iv) adjustments or modifications made by the American Medical Association (AMA); (v) adjustments resulting from use of an inaccurate formula in calculating a price stated in the Reimbursement Notice; (vi) adjustments resulting from clerical errors, such as errors in computation or data entry; (vii) services which are not priced individually and are deemed to be "By Report"; and (viii) payment rates for new technologies. To the extent this provision is inconsistent with any other provisions of this Agreement, this provision supersedes all such other provisions.

The Provider agrees to accept as full compensation for services such payments as are received from the Corporation under the terms hereof and of the Subscriber's contracts.

**Reimbursement Provision from BCBSND Application of and Agreement with Participating Physicians**

**ARTICLE I**

A. The Corporation will reimburse the Participating Physician for Covered Services on a fee equal to the lesser of 1) the Participating Physician's billed charges or 2) based on the BCBSND payment system in effect at the time the services are provided, excluding Cost Sharing Amounts, and as set forth in the Reimbursement Notice. The Reimbursement Notice is composed of separate schedules and information which fully identify the BCBSND payment system. The total compensation set forth in the Reimbursement Notice includes information sufficient for the Participating Physician to determine the compensation for services and procedures rendered pursuant to the provision of Covered Services, including:

1. The manner of payment, such as fee-for-service, capitation, or risk sharing;

2. The fee schedule for services reasonably expected to be billed by the Participating Physician for services provided pursuant to this Agreement. BCBSND shall provide, upon request, the fee schedule for any other services reasonably expected to be billed by the Participating Physician. BCBSND shall make available a fee schedule for the services when a material change occurs. A Participating Physician who receives fee schedule information may only use or disclose the information for the purpose of practice management, billing activities, and other business operations; and

3. The methodology used for any fee schedule, such as relative value unit system and conversion factor, percentage of Medicare payment system, or percentage of billed charges. As applicable, the methodology disclosure shall include the name of any relative value system, its version, edition, or publication date, and any applicable conversion or geographic factor. BCBSND shall state the material effects of edits, if any, on payment or compensation.

Upon request, BCBSND shall provide a description and copy of the coding guidelines, including any underlying bundling, or other payment process applicable to specific services under the Agreement. A Participating Physician may only use or disclose the information for the purpose of practice management, billing activities, and other business operations.

B. Except as provided below, changes to the BCBSND payment system as set forth in the Reimbursement Notice shall be permitted only once every calendar year and no payment withholds may be imposed. Notice of such annual changes shall be sent to the Provider at least 5 days prior to the effective date of the annual changes.

The Participating Physician specifically acknowledges and agrees that the limit on annual changes to the BCBSND payment system imposed under this provision shall not apply to adjustments or modifications imposed exclusively as a result of any of the following: (i) quarterly pharmacy/injectable drug adjustments, medical supplies and other goods; (ii) scheduled coding changes for CPT®/HCPCS codes; (iii) adjustments or modifications made by the Centers for Medicare and Medicaid Services (CMS); (iv) adjustments or modifications made by the American Medical Association (AMA); (v) adjustments resulting from use of an inaccurate formula in calculating a price stated in the Reimbursement Notice; (vi) adjustments resulting from clerical errors, such as errors in computation or data entry; (vii) services which are not priced individually and are deemed to be "By Report"; and (viii) payment rates for new technologies. To the extent this article is inconsistent with any other provisions of this Agreement, this article supersedes all such other provisions.

The Participating Physician agrees to accept as full compensation for services such payments as are received from the Corporation under the terms hereof and of the Subscriber's contracts

**BlueCross BlueShield of North Dakota**

*An independent licensee of the Blue Cross & Blue Shield Association*

4510 13th Avenue South
Fargo, North Dakota 58121-0001

TO: «Title», «Hospital»
FROM: Donald P. Schott, Assistant Vice President Provider Reimbursement
DATE: October 29, 2008
RE: 2009 Institutional Provider Reimbursement Notice

Section 2.1 of the Blue Cross Blue Shield of North Dakota (BCBSND) hospital participation agreement requires that BCBSND notify providers of annual changes to the payment system at least 60 days prior to the effective date of such changes.

As you know, reimbursement to our participating providers, for services rendered to our members, is dependent on the premium dollars received to cover such services. We are currently in discussions with the North Dakota Department of Insurance regarding premium rate increases for 2009. Accordingly, without knowing next year's premium rates, we are not in a position to determine reimbursement changes. We are hopeful that, in the next two to three weeks, we will be able to provide further notice of changes to the 2009 institutional fee schedules. If provider fee schedules receive an overall increase, the changes will be effective January 1, 2009. In the unlikely event of fee schedule decreases, changes will be implemented the first day of the month following the 60-day notice.

We understand your frustration of the unknown and your need for reimbursement information to properly plan and budget finances for the upcoming year. We are doing everything we can to move this process forward as quickly as possible. Thank you for your participation and continued patience as we work to resolve this challenging situation.

If you have further questions, please contact me at 701-277-2028 or don.schott@bcbsnd.com.

**BlueCross BlueShield of North Dakota**

*An independent licensee of the Blue Cross & Blue Shield Association*

4510 13th Avenue South
Fargo, North Dakota 58121-0001

TO: «Title», «Hospital»
FROM: Donald P. Schott, Assistant Vice President Provider Reimbursement
DATE: December 23, 2008
RE: Hospital Fee Schedules Effective for Dates of Service Beginning January 1, 2009

Pursuant to the provider reimbursement notice dated October 29, 2008, please find enclosed a CD containing the 2009 Blue Cross Blue Shield of North Dakota (BCBSND) UB-04 Inpatient DRG Rate Schedule, the Reference Lab list, Hospital Outpatient Fee Schedule, Home Health Fee Schedule, and the Anesthesia Fee Schedule. Other fee schedules on the disk may include, if applicable to your facility, Transitional Care Unit (TCU), Swingbed, Inpatient Psych/Substance Abuse, Inpatient Rehab and Long Term Acute Care.

Payment is based on the lesser of charge or fee schedule amount for all outpatient services. Inpatient services are reimbursed at the fee schedule amount. All fee schedules are in Excel format with the exception of the Anesthesia Fee Schedule which is in Word.[1] Please note the enclosed fee schedules are **confidential** and for your internal use only. Any other use or redistribution of these fee schedules without the written consent of BCBSND is prohibited.

BCBSND will continue to reimburse mid-tier and rural hospitals at 115% and 125% respectively for both the Hospital Outpatient and Home Health Fee Schedule rates. These differentials are reflected in the enclosed fee schedules. See Attachment 1 for the listing of these facilities. Specific product discounts or contractual arrangements that your facility may have with BCBSND are not reflected in the enclosed fee schedules.

The fee schedules contain several changes for 2009. In general, a 4% overall increase will be applied to all fee schedule rates with a few exceptions as noted below. Additional payment will be applied for behavioral services rendered in a residential treatment center to complete the transition of these rates.

The rate increases are applied after adjustments for budget neutrality are made to the DRGs, outpatient surgical rates, and other applicable fee schedules to accommodate for the relative weighting changes. Individual hospital impacts will differ depending on how the refinement of fee schedules affects each hospital's case mix.

The **4% increase does not apply to** Home Medical Equipment; Level I Partial Hospitalization Substance Abuse Services; Injectables, J-Codes and Related Pharmacy.

For a better understanding of the major reimbursement changes for 2009, the following details are provided.

1. DRGs – Inpatient stays will be reimbursed based on Grouper version 26.0 of the Medicare Severity Diagnostic Related Groups (MS-DRGs) as employed in CMS's

[1] If you need your files in a format other than Excel or Word, please notify us. Also, if you need your fee schedules on disk versus CD, please notify us and a compatible medium will be sent immediately.

Inpatient Prospective Payment System. 2009 CMS MS-DRG weights will be used to set reimbursement relative to each DRG, with the following exceptions:

- The maternity and newborn weights will continue to be based on North Dakota's provider charges. The base rate has been established through a budget neutral calculation by applying the new grouper to historical claims and reassigning to the appropriate MS-DRG.
- An amount based on average organ acquisition cost has been added to the DRG rate for MS-DRGs 8 (simultaneous pancreas/kidney transplant), 10 (pancreas transplant), and 652 (kidney transplant) in lieu of adding the specific cost associated with each organ per individual case.

2. Inpatient Outlier Threshold – The inpatient outlier fixed dollar threshold will decrease from $36,621 to $35,652.

3. Long-Term Acute Care - Long-term acute care stays will be grouped based on the new MS-DRG grouper. The rates will be recalibrated based on Medicare's 2009 per diem rates.

4. Swingbed/Transitional Care Unit (TCU) – Swingbed and TCU rates will continue to be based on an all-inclusive per diem rate and will reflect the 2009 Resource Utilization Group (RUG) average for their respective category.

5. Reimbursement for therapeutic radiology technical services, physical therapy, occupational therapy, speech therapy services and mammography outpatient services remain standardized for hospital-based and freestanding entities. The changes in the 2009 fee schedule amounts are due to the updating for the one-year lag of the 2008 RVUs and the across-the-board increase of 4%.

6. Reimbursement for diagnostic radiology codes with an APC status indicator of "S" continues to be based on 125-150% of the technical component of the 2008 BCBSND Physician Payment Schedule (PPS). Radiology codes with an APC status indicator of "X" continue to be reimbursed at 125% of the PPS reimbursement. Changes in the 2009 fee schedule amounts are due to the updating for the one-year lag of the 2008 RVUs and the across-the-board increase of 4%.

7. PET Scans - PET scan rates will be based on CMS's proposed 2009 APC amount. The radiopharmaceutical will continue to receive separate payment.

8. Outpatient Lab – Codes based on Medicare's Clinical Lab Fee Schedule will be paid at approximately 205% of the 2008 Medicare rate, after the 4% increase is applied.

9. Reference Lab – The reference lab list is composed of codes that will be reimbursed at 100% of charges when performed at a reference lab and billed with modifier 90. CPT® codes 87187, 88155, 88312 and 88313 will be added to the list for 2009. Providers are encouraged to append modifier 90 to procedures sent to a reference lab. Providers should bill charges imposed by the reference lab for all tests sent to a reference lab even if they are not currently on the reference lab list.

10. Outpatient Surgical Rates - The hospital outpatient surgical rates are based on Medicare's proposed 2009 OPPS APCs. The surgical rates will be recalibrated using Medicare's APCs prior to wage index adjustments.

11. Significant Outpatient Surgical Procedures – The following surgical procedures have been increased to a rate halfway between the 2009 MS-DRG rate and the proposed 2009 outpatient rate.

| CPT® Code | Description | CPT® Code | Description |
|---|---|---|---|
| 33240 | Insertion of single/dual pulse generator | 63005 | Laminectomy, 1 or 2 segments, lumbar |
| 33249 | Insert/Reposition leads, generator | 63030 | Hemilaminectomy, 1 interspace, lumbar |
| 43280 | Laparoscopy, surgical, esophagogastric fundoplasty | 63267 | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar |
| 43770 | Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device | 64590 | Insert/replace neurostimulator generator or receiver |
| 63003 | Laminectomy, 1 or 2 segments, thoracic | | |

12. Home Medical Equipment - Home Medical Equipment rates will continue to be based on 110% of the 2009 Medicare Fee Schedule.

13. Psychiatric Facility Fee – Fee schedule amounts on the Hospital Outpatient Fee Schedule will represent a facility fee for the psychiatric CPT® codes 90801-90899, with the exception of Electroconvulsive Therapy (90870). The outpatient rates will be based on the site of service (SOS) differential from the Physician Payment Schedule (PPS) if one is available. Codes without a SOS differential will be based on APCs. Therefore, payment will be for the overhead costs of the facility only. The facility fee for outpatient services should continue to be billed on the UB-04 claim form. The corresponding professional psychiatric services associated with those outpatient services must be submitted on the CMS-1500 claim form. Also effective January 1, 2009, BCBSND will only use claims submitted on the CMS-1500 to accumulate the member's hourly benefit maximum for these psychiatric services.

14. Dialysis Support Services - Reimbursement for dialysis services (i.e. Hemodialysis, Continuous Ambulatory Peritoneal Dialysis & Continuous Cycling Peritoneal Dialysis) will include any support service provided. Charges billed separately with support services revenue codes 0825, 0835, 0845 or 0855 will be denied as included in the dialysis rate.

15. Chemotherapy Administration - CPT® codes 96401-96549 (with the exception of 96521, 96522 and 96523) will only be allowed when billed for administration of infliximab (J1745), decitabine (J0894) or a chemotherapy drug (J9001-J9999). Claims submitted with a chemotherapy administration code, but without one of these drugs, will be held and reviewed individually.

CPT®/HCPCS codes that are not on the fee schedule are considered to be "by report". They are manually reviewed and payment is determined on an individual basis.

The existence of a procedure code on these fee schedules is not a guarantee the code is valid or covered. These fee schedules may contain procedure codes that have been replaced by other HCPCS or CPT® codes. Edits in BCBSND's system check for procedure validity and will reject invalid codes. Some codes may represent services for which benefits are not available.

If you have further questions after reviewing the schedules, please contact me at 701-277-2028 or don.schott@bcbsnd.com.

ATTACHMENT I

## BCBSND PARTICIPATING RURAL HOSPITALS

| | |
|---|---|
| Ashley Medical Center | Ashley |
| Carrington Health Center | Carrington |
| Cavalier County Memorial Hospital | Langdon |
| Community Memorial Hospital | Turtle Lake |
| Cooperstown Medical Center | Cooperstown |
| First Care Health Center | Park River |
| Fort Yates Hospital | Fort Yates |
| Garrison Memorial Hospital | Garrison |
| Heart of America Medical Center | Rugby |
| Jacobson Memorial Hospital | Elgin |
| Kenmare Community Hospital | Kenmare |
| Kittson Memorial Hospital | Hallock |
| Linton Hospital | Linton |
| Lisbon Medical Center | Lisbon |
| McKenzie County Memorial Hospital | Watford City |
| Medical Center - Hospital | Hillsboro |
| Mercy Hospital | Valley City |
| Mercy Hospital | Devils Lake |
| Mountrail County Medical Center | Stanley |
| Nelson County Health System | McVille |
| Northwood Deaconess Health Center | Northwood |
| Oakes Community Hospital | Oakes |
| Pembina County Memorial Hospital | Cavalier |
| Presentation Medical Center | Rolla |
| Quentin Burdick Comp Facility | Belcourt |
| Richardton Health Center | Richardton |
| Riverview Healthcare Association | Crookston |
| Sakakawea Medical Center | Hazen |
| St. Aloisius Medical Center | Harvey |
| St. Andrew's Health Center | Bottineau |
| St. Luke's Hospital | Crosby |
| Southwest Health Care Services | Bowman |
| Tioga Medical Center | Tioga |
| Towner County Medical Center | Cando |
| Union Hospital | Mayville |
| Unity Hospital | Grafton |
| West River Regional Medical Center | Hettinger |
| Wishek Community Hospital | Wishek |

## BCBSND PARTICIPATING MID-TIER HOSPITALS

| | |
|---|---|
| Jamestown Hospital | Jamestown |
| St. Joseph's Hospital | Dickinson |
| Mercy Hospital | Williston |

Kathy Hoeft
Ashley Medical Center
PO Box 450
[redacted]y, ND 58413

Gary Miller
St. Alexius Medical Center
900 E Broadway
Bismarck, ND 58502

Darrold Bertsch
Southwest Health Care Services
PO Box C
Bowman, ND 58623

Everett Butler
Pembina County Memorial Hospital
301 Mountain Street E
Cavalier, ND 58220

Leslie Urvand
St. Luke's Hospital
702 1st Street SW
Crosby, ND 58730

[redacted]pdahl
Jacobson Memorial Hospital
601 East St. N
Elgin, ND 58533

Dr. Roger Gilbertson
Meritcare Hospital
720 N 4th Street
Fargo, ND 58122

Administrator
Fort Yates Hospital
North River Road
Fort Yates, ND 58538

Bonnie Jo Rice
Richard P. Stadter Psych
1451 44th Avenue South
Grand Forks, ND 58208

[redacted] Carlson
[redacted]n Memorial Hospital
1010 S Birch Avenue
Hallock, MN 56728

Linus Everling
Quentin Burdick Comp Facility
P.O. Box 160
Belcourt, ND 58316

James Cooper
Medcenter One
300 N 7th Street
Bismarck, ND 58502

Jac McTaggert
Towner County Medical Center
PO Box 688
Cando, ND 58324

Gregory Stomp
Cooperstown Medical Center
1200 Roberts Avenue NE
Cooperstown, ND 58425

Marlene Krein
Mercy Hospital
1031 7th Street
Devils Lake, ND 58301

Custer Huseby
Triumph Hospital
1720 South University Drive
Fargo, ND 58103

Martha Leclerc
Meritcare Hospital
720 N 4th Street
Fargo, ND 58122

Dean Mattern
Garrison Memorial Hospital
407 3rd Avenue SE
Garrison, ND 58540

Dave Molmen
Altru Hospital
1200 S Columbia Road
Grand Forks, ND 58206

Rocky Zastoupil
St. Aloisius Medical Center
325 E Brewster
Harvey, ND 58341

Andrew Wilson
St. Alexius Medical Center
900 E Broadway
Bismarck, ND 58502

Jodi Atkinson
St. Andrews Health Center
316 Ohmer Street
Bottineau, ND 58318

Mariann Doeling
Carrington Health Center
PO Box 461
Carrington, ND 58421

Carol Sanders
Riverview Healthcare Association
323 S Minnesota Street
Crookston, MN 56716

Attn: Administrator
St. Joseph's Hospital
30 W 7th St
Dickinson, ND 58601

Dr. Greg Glasner
Innovis Health
3000 32nd Avenue SW
Fargo, ND 58103

Richard Failla
Prairie St. John's
PO Box 2027
Fargo, ND 58107-2027

Everett Butler
Unity Medical Center
164 W 13th Street
Grafton, ND 58237

Dwight Thompson
Altru Hospital
1200 S Columbia Road
Grand Forks, ND 58206

Jim Marshall
Sakakawea Medical Center
510 8th Avenue NE
Hazen, ND 58545

Jim Long
West River Regional Medical Center
1000 Highway 12
[redacted]nger, ND 58639

Patty Dirk
Hillsboro Medical Center-Hospital
12 3rd Street SE
Hillsboro, ND 58045

Martin Richman
Jamestown Hospital
419 5th Street NE
Jamestown, ND 58401

Mr. Alex Schweitzer
North Dakota State Hospital
2605 Circle Drive
Jamestown, ND 58401

Ms. Shawn Smothers
Kenmare Community Hospital
317 1st Avenue NW
Kenmare, ND 58746

Lawrence Blue
Cavalier County Memorial Hospital
909 2nd Street
Langdon, ND 58249

Roger Unger
Linton Hospital
518 N Broadway
Linton, ND 58552

Peggy Larson
Lisbon Medical Center
PO Box 353
Lisbon, ND 58054

Cora Pifer
Triumph Hospital
1000 18th Street NW
Mandan, ND 58554-1612

Roger Baier
Union Hospital
42 6th Avenue SE
Mayville, ND 58257

Cathy Swenson
Nelson County Health System
200 North Main Street
McVille, ND 58254

Kevin Seehafer
Trinity Hospital
1 Burdick Expressway W
Minot, ND 58701

Terry Hoff
Trinity Hospital
1 Burdick Expressway W
Minot, ND 58701

Pete Antonson
Northwood Deaconess Health Ctr
PO Box 190
Northwood, ND 58267

John Osse
Oakes Community Hospital
1200 N 7th Street
Oakes, ND 58474-2502

[redacted]ouise Dryburgh
First Care Health Center
115 Vivian Street
Park River, ND 58270

Jim Opdahl
Richardton Health Center
212 3rd Avenue W
Richardton, ND 58652

Kimber Wraalstad
Presentation Medical Center
213 2nd Avenue NE
Rolla, ND 58367

Jerry Jurena
Heart of America Medical Center
800 S. Main Avenue
Rugby, ND 58368

Mitch Leupp
Mountrail County Medical Center
PO Box 399
Stanley, ND 58784

Randy Pederson
Tioga Medical Center
PO Box 159
Tioga, ND 58852

Dean Mattern
Community Memorial Hospital
220 5th Avenue
Turtle Lake, ND 58575-0280

Keith Heuser
Mercy Hospital of Valley City
570 Chautauqua Blvd
Valley City, ND 58072

Daniel Kelly
McKenzie County Memorial Hospital
516 N Main
Watford City, ND 58854

Dennis Goebel
Mercy Medical Center
1301 15th Avenue W
Williston, ND 58801

Trina Schilling
Wishek Community Hospital
1007 4th Avenue S
Wishek, ND 58495

[redacted]

**BlueCross BlueShield of North Dakota**

*An independent licensee of the Blue Cross & Blue Shield Association*

4510 13th Avenue South
Fargo, North Dakota 58121-0001

TO: Blue Cross Blue Shield of North Dakota Participating Providers
FROM: Donald P. Schott, Assistant Vice President, Provider Reimbursement
DATE: December 23, 2008
RE: 2009 Physician Payment Schedule and Other CMS-1500 Fee Schedules

Enclosed please find a CD containing the 2009 Blue Cross Blue Shield of North Dakota (BCBSND) Physician Payment Schedule (PPS), Clinical Laboratory Fee Schedule, Ambulatory Surgery Center (ASC) Fee Schedule, Anesthesia Fee Schedule, Injectables/Other Pharmacy Fee Schedule, Home Medical Equipment (HME) Fee Schedule, Reference Laboratory list and Assistant at Surgery list.[1]

Payment is based on the lesser of charge or fee schedule amount. Specific product discounts or contractual arrangements that you may have with BCBSND are not reflected in the fee schedules. Please note the enclosed fee schedules are **confidential** and for your internal use only. Any other use or redistribution of these fee schedules without the written consent of BCBSND is prohibited.

The fee schedules contain several changes for 2009. In general, a 4% overall increase will be applied to all fee schedule rates except the Injectables/Other Pharmacy Fee Schedule and HME Fee Schedule. Additional increases will be applied to preventive medicine services to continue their transition to full relative value.

BCBSND bases the PPS on the Medicare Resource Based Relative Value Scale and Year 2009 Transitional Relative Value Units (RVUs) as published November 19, 2008 in the *Federal Register*.[2] The new BCBSND conversion factor effective January 1, 2009 is $56.61. The new conversion factor was calculated by neutralizing the 2008 conversion factor for the effects of the changes in RVUs and increased by 4%.

The PPS indicates the rates reimbursable to physicians. In some instances, rates applied to allied providers are based on a percentage of the rate indicated on the PPS.

For a better understanding of the major reimbursement changes for 2009, the following details are provided.

1. Preventive Medicine Services (CPT® codes 99381 – 99397) – Currently, preventive medicine services are reimbursed based on 75% of the RVU. Beginning January 1, 2009, BCBSND will base its payment on 87.5% of Medicare's RVU. This change was calculated outside of the conversion factor calculation.

2. Outpatient Lab – Codes based on Medicare's Clinical Lab Fee Schedule will be paid at approximately 205% of the 2008 Medicare rate, after the 4% increase is applied.

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[1] If you need your files in a format other than Excel or Word, please notify us. Also, if you need your fee schedules on disk versus CD, please notify us and a compatible medium will be sent immediately.

[2] Therapeutic radiology codes are based on BCBSND's conversion factor. The technical portion is reimbursed at 125 percent of the RVU multiplied by the conversion factor. The global reimbursement is the sum of the technical and professional components. Preventive medicine is based on 7/8 of the RVU and immunization administration is based on 3/4 of the RVU.

3. Reference Lab – The reference lab list is composed of codes that will be reimbursed at 100% of charges when performed at a reference lab and billed with modifier 90. CPT® codes 87187, 88155, 88312 and 88313 will be added to the list for 2009. Providers are encouraged to append modifier 90 to procedures sent to a reference lab. Providers should bill charges imposed by the reference lab for all tests sent to a reference lab even if they are not currently on the reference lab list.

4. ASC Facility Fees - Facility fees for surgical procedures performed in an ASC will be based on Medicare's proposed 2008 OPPS APCs with a few exceptions[3]. The rates will be recalibrated using Medicare's APCs prior to wage index adjustments.

5. Significant ASC Surgical Procedures – The following surgical procedures have been increased to a rate halfway between the 2009 MS-DRG rate and the proposed 2009 ASC rate.

| CPT® Code | Description |
|---|---|
| 43770 | Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device |
| 63030 | Hemilaminectomy, 1 interspace, lumbar |
| 64590 | Insert/replace neurostimulator generator or receiver |

6. Chemotherapy Administration - CPT® codes 96401-96549 (with the exception of 96521, 96522 and 96523) will only be allowed when billed for administration of infliximab (J1745), decitabine (J0894) or a chemotherapy drug (J9001-J9999). Claims submitted with a chemotherapy administration code, but without one of these drugs, will be held and reviewed individually.

7. Chiropractic Manipulative Treatment – Effective January 1, 2009, when an extraspinal region manipulation (98943) is performed on the same patient on the same day as a spinal manipulation (98940, 98941, 98942), reimbursement for the extraspinal manipulation will not be reduced. Reimbursement will be based on the full PPS amount for spinal and extraspinal manipulations when billed together.

8. Home Medical Equipment - Home Medical Equipment rates will continue to be based on 110% of the 2009 Medicare Fee Schedule. *Note: Effective January 1, 2009, K0009 (Other manual wheelchair/base) will be considered "By Report" and will be reviewed and paid on an individual basis. Please disregard the dollar amount listed on the fee schedule.*

The existence of a procedure code on these fee schedules is not a guarantee the code is valid or covered. These fee schedules may contain procedure codes that have been replaced by other HCPCS or CPT® codes. Edits in BCBSND's system check for procedure validity and will reject invalid codes. Some codes may represent services for which benefits are not available.

If you have any questions after reviewing the fee schedules, please contact me at 701-277-2028 or don.schott@bcbsnd.com.

[3] Certain office-based procedures are rated based either on the PPS site of service differential or the 2009 final ASC APC amount. A few significant procedures are priced based on the mid-point of the 2009 BCBSND DRG rate and the 2009 proposed Hospital Outpatient rate.

**Testimony in opposition to Senate Bill 2397**
**Senate IBL Committee, February 10, 2009**

Chairman Klein and members of the Senate IBL Committee. My name is Pat Ward and I represent Medco Health Solutions in opposition to this bill.

As those of you know who were here two sessions ago, a Pharmacy Benefits Manager is the company that manages contracts for a health insurer, provides a pharmacy network and negotiates purchases of pharmaceuticals to ultimately be supplied to the health insurer's customers and their beneficiaries.

After lengthy debate, this legislature adopted rules governing the way in which PBM's operate. Those rules are enacted in Section 26.1-27.1 of the North Dakota Century Code. I have attached a copy of that section to my testimony.

While it appears that the intended consequence of this bill is to regulate the relationship between a health insurer and a doctor or other provider, we believe that the bill paints with too broad a brush. The bill as drafted may impact several entities not intended to be impacted by this legislation. Pursuant to North Dakota law, a PBM is required to register as a third party administrator (TPA). This bill brings in TPA's under its wide umbrella. We would ask that a carve out be made for groups such as Medco and other PBMs and, frankly, any other unintended victims of this proposed legislation.

North Dakota has already enacted a very comprehensive PBM law which allows the Insurance Commissioner to see the contracts between a health insurer and a pharmacy benefits manager. These contracts are very complex and have their own audit rules. In addition, North Dakota has an extremely lengthy unfair claims practices act which also covers many of these other people who may be brought into the crosshairs by the unintended consequences of this legislation. I have brought that

section with me if you would like to read it, although I have not copied it because it is ten pages.

You have heard a great deal of testimony today from the people directly impacted by this bill as to why you should kill this bill. I am here to point out to you that whether or not you were persuaded by that testimony, it is necessary for you to amend this bill to avoid unintended consequences which at this point can only be imagined.

Although the prime Senate sponsor of this bill is a "hard core" regulator, I would urge you to amend the bill to exclude PBMs and I would also urge a do not pass on Senate Bill 2397, at least in its present form.

Chairman Klein and members of the committee, My name is Jon Rice. I am the Chief Medical Officer at Blue Cross Blue Shield North Dakota. I am also a member of the North Dakota and American Medical Associations. I rise to point out several concerns about the language in Senate Bill 2397.

The bill states, "A health care payer may not combine any individually submitted coded services unless such action conforms with the American medical association's current procedural terminology coding guideline in effect on the date of the service, including the use of current procedural terminology modifiers, add-on codes, and modifier fifty-one exempt codes, and in accordance with contractually agreed-upon bundling practices and policies." The current Current Procedural Terminology (CPT) book, in its discussion about combining codes and the markings for codes to be combined in the book, comments, "These instructions are not intended as a listing of all possible code combinations that should not be reported, nor to indicate all possible code combinations that are appropriately reported." It goes on to suggest that CPT Assistant and other collaborative publications should be used. This bill references an inadequate source by its own admission. Is the expectation that additional books are also incorporated by reference? Correct coding is an area of rapid changes and multiple shades of gray. Exact determinations can require significant expertise. In Figure 1 at the end of my testimony we show an example related to immunizations. Should code A4206 for an injection supply be allowed in addition to the office call, vaccine cost and administration fee for the vaccine? The information is not specifically listed in the CPT code book. Perhaps a.54 cent additional fee does not sound like much, but when multiplied by over 300,000 immunizations annually it comes to almost $174,000. This is one example. Does the Insurance Commissioner's office have the expertise and time to administer these gray areas?

In regard to the need to provide a 60 day notice and opportunity to terminate the contract in the face of a "material change." ( "change which decreases the health

care provider's payment or compensation for medical services or reimbursement for medical goods or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense.") more specificity is needed. There are enough flexible words in that phrase to keep a whole state house of lawyers busy for years. "may reasonably be expected" and "significantly increase" should be quantified if they are required as part of contract language. This phrase also means that any decrease that occurs requires notice and an opportunity to terminate. Basically this creates a new contract. We currently adjust medication prices on a quarterly basis to try remain current with pharmacy changes. This process would require new contracts, approval by the Commissioner and extensive notification. Is this a reasonable requirement? Does the State have the resources to review all these contracts?

Review mechanism must be conducted in a timely manner in paragraph 6. A reasonable review mechanism must be included. What is timely? Who defines? What is a reasonable review mechanism?

Paragraph 7 includes the phrase, "data commonly requested. How is commonly defined?

Paragraph 8 indicates that after a six-month time period the payer may not recoup improperly paid claims dollars. A recent presentation by the American Academy of Coding Professionals commented that most audits take 6-12 months. Our usual evaluations of patterns occur in April after billings have been completely processed for the prior calendar year. Unusual patterns of coding or care generally drive audit requests. Other drivers of audits are complaints about services or bills from a provider. Audits of provider's claims and coding practices are a major protection mechanism for the citizens of the state. As much as we would all like to believe that this is a perfect world I must inform the committee that there are providers who intentionally or unintentionally operate in the gray

areas of coding or are not always 100% truthful in their communications related to insurance coverage. I would hate to see a restrictive law such as this dismantle an activity that I consider effective and appropriate. Examples of recent audit findings include a physician billing for the services of a nurse practitioner as if the physician provided the service, a psychology provider billing excessive and inappropriate high level codes, a speech therapist double billing for services, a physician billing for non-covered services, a telemedicine provider billing mid-level services as if provided by the physician, a counselor billing excessive and inappropriate high level codes, a clinic billing for non-covered services and providing not medically necessary services, a mental health facility providing services not supported by the medical record, urgent care facility billing high level codes with inadequate documentation to support, a mental health facility with prolonged lengths of stay not justified by the medical record. After evaluation and consultation with the providers involved, correction of these activities and recoupment of excessive payments have resulted in over $2 million dollars of reduced costs to the insured members of Blue Cross Blue Shield of North Dakota.

The last page of the bill includes additions in regard to practice profiling. For the information of the committee a sample practice report is included as Figure 2. This report is distributed to individual providers and to their networks. BCBSND has shared this information with the physician community as an support and educational tool. It has not been made available to the public. The report places the individual physician on a grid in regard to quality of care and cost-efficiency of care. Information relating to the quality of care determination is provided. Nationally accepted measures are used as the determinants of the quality score. I serve as a member of a medical advisory committee to one of the national financial and quality profiling organizations. In this role, I am very aware of the absence of a national standard for the measurement of cost-efficiency. While there are good national measures in regard to quality, that available for cost-

efficiency can best be labeled as in-development. Requiring a national standard that does not exist makes any performance in the area impossible.

Although we will work with any provider or group of providers if there are perceived inaccuracies in our reports, we do not feel that a formal process need be in place for work that we do directly with our providers. Should a provider profile be disseminated publicly, we believe that there should be a peer review appeal process. The law as written is unclear to us as to whether the statute applies to profiling and comparison work done for internal purposes or for profiling reports that are intended for the public arena.

In summary, as a member of the Blue Cross Blue Shield North Dakota administrative team, we have multiple concerns about the bill in regard to contracting. The bill is potentially disruptive to business as it is conducted today, it makes rapid adjustments to market changes impossible and creates a level of regulation and cost that is unprecedented and unnecessary. In regard to the profiling area, we believe that these provisions are appropriate (with the exception of a national standard for cost-efficiency) if profiling results are for public consumption the role of this section should be clarified.

I would be happy to respond to your questions.

Injection Administration Supplies

| Procedure | Definition | FS Amt | Related Edit |
|---|---|---|---|
| 99213 | Mid-level office call | $ 96.24 | |
| 90471 | Flu Shot Administration | $ 24.63 | |
| A4206 | Syringe with needle - supply for injection | $ 0.54 | The cost of the syringe is built into the FS rate for the flu shot administration code. This service is considered a component of that code and is "bundled" into the 90471. |
| 90658 | Influenza virus vaccine | $ 12.29 | |

When a member goes to the physician for an office call and also receives a flu shot, the injection & vaccine can be billed separately from the office call service; however the injection administration code includes any supplies used so the syringe cannot be billed separately. An edit is in place to prevent this from happening. The member is saved additional cost share on a service that should not have been broken out and billed separately.

This information is applicable to all injection administration codes and would apply to all of those services as well.

This information is not specifically listed in CPT although the administration codes have guidance about supplies being included.

To date there have been 77,564 influenza vaccines given in 2008. If unbundling of the supplies could not be edited for, this would be an increased payment of $41,884.56 which would also have additional cost share applied.

To date there have been 244,466 other immunizations given in 2008 that the same bundling rule applies to. If this could not be edited for, this would be an increased payment of $132,011.64.

Total overpayment of $173,896.20 for a $.54 syringe for immunizations only.

BlueCross BlueShield North Dakota

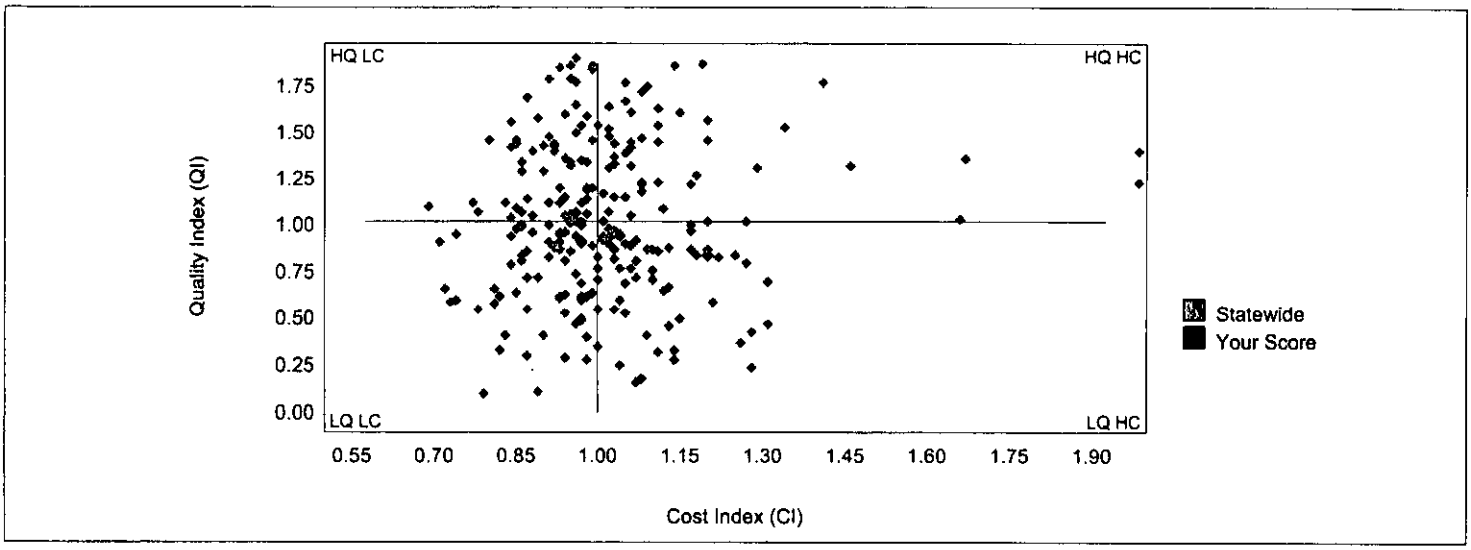
# BLUE CROSS BLUE SHIELD OF NORTH DAKOTA REPORT
# 2007 QUALITY REPORT

**PHYSICIAN NAME**
**PHYSICIAN SPECIALTY**
**NETWORK**

2007 Quality Index: 1.07

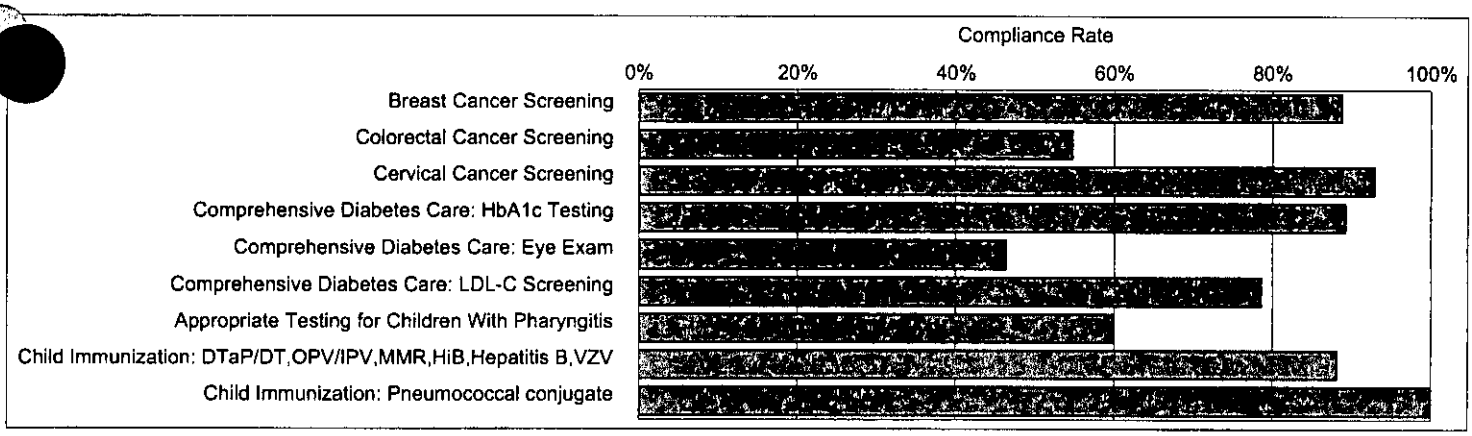
2007 Cost Index: 1.12

**Quality and Cost Index Distributions for SPECIALTY**




* statistically significant p=.05

**Quality Measure Compliance Summary**




| Quality Measure | Elig Patients | Compliant Patients | Compliance Rate | National Rate | Rank |
|---|---|---|---|---|---|
| Breast Cancer Screening | 161 | 143 | 88.8% | 70.7% | 40 / 236 |
| Beta-Blocker Treatment After a Heart Attack | 2 | 2 | 100.0% | 98.2% | |
| Colorectal Cancer Screening | 199 | 109 | 54.8% | 57.6% | 128 / 236 |
| Cervical Cancer Screening | 199 | 185 | 93.0% | 82.5% | 25 / 236 |
| Use of Appropriate Medications for People With Asthma: All Ages | 13 | 12 | 92.3% | 92.0% | |
| Comprehensive Diabetes Care: HbA1c Testing | 28 | 25 | 89.3% | 88.7% | 83 / 96 |
| Comprehensive Diabetes Care: Eye Exam | 28 | 13 | 46.4% | 59.7% | 65 / 96 |
| Comprehensive Diabetes Care: LDL-C Screening | 28 | 22 | 78.6% | 84.8% | 78 / 96 |
| Appropriate Testing for Children With Pharyngitis | 20 | 12 | 60.0% | 71.3% | 14 / 51 |
| Antidepressant Medication Mgmt: Effective Acute Phase Treatment | 5 | 4 | 80.0% | 63.2% | |
| Antidepressant Medication Mgmt: Effective Continuation Phase Treatment | 5 | 3 | 60.0% | 46.3% | |
| Child Immunization: DTaP/DT,OPV/IPV,MMR,HiB,Hepatitis B,VZV | 17 | 15 | 88.2% | 81.3% | 15 / 30 |
| Immunization: Pneumococcal conjugate | 17 | 17 | 100.0% | 77.2% | 1 / 30 |
| | 697 | 541 | | | |

Note: The shaded measures were used to calculate the quality index (QI).

# PROPOSED AMENDMENTS TO SENATE BILL NO. 2397

Page 1, line 14, after the period, add "This section does not apply to a "pharmacy benefits manager" as defined in section 26.1-27.1 or a pharmacy benefits contract which is regulated by 26.1-27.1"

Renumber accordingly

# CHAPTER 26.1-27.1
## PHARMACY BENEFITS MANAGEMENT

**26.1-27.1-01. Definitions.** In this chapter, unless the context otherwise requires:

1. "Covered entity" means a nonprofit hospital or a medical service corporation; a health insurer; a health benefit plan; a health maintenance organization; a health program administered by the state in the capacity of provider of health coverage; or an employer, a labor union, or other entity organized in the state which provides health coverage to covered individuals who are employed or reside in the state. The term does not include a self-funded plan that is exempt from state regulation pursuant to the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.]; a plan issued for coverage for federal employees; or a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, long-term care, or other limited-benefit health insurance policy or contract.

2. "Covered individual" means a member, a participant, an enrollee, a contractholder, a policyholder, or a beneficiary of a covered entity who is provided health coverage by the covered entity. The term includes a dependent or other individual provided health coverage through a policy, contract, or plan for a covered individual.

3. "De-identified information" means information from which the name, address, telephone number, and other variables have been removed in accordance with requirements of title 45, Code of Federal Regulations, part 164, section 512, subsections (a) or (b).

4. "Generic drug" means a drug that is chemically equivalent to a brand name drug for which the patent has expired.

5. "Labeler" means a person that has been assigned a labeler code by the federal food and drug administration under title 21, Code of Federal Regulations, part 207, section 20, and that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.

6. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:

   a. A rebate collected by the pharmacy benefits manager which is allocated to a covered entity;

   b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;

   c. A pharmacy network fee; and

   d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.

7. "Pharmacy benefits management" means the procurement of prescription drugs at a negotiated rate for dispensation within this state to covered individuals; the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals; or the providing of any of the following services with regard to the administration of the following pharmacy benefits:

a. Claims processing, retail network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;

b. Clinical formulary development and management services; or

c. Rebate contracting and administration.

8. "Pharmacy benefits manager" means a person that performs pharmacy benefits management. The term includes a person acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. The term does not include a public self-funded pool or a private single-employer self-funded plan that provides benefits or services directly to its beneficiaries. The term does not include a health carrier licensed under title 26.1 if the health carrier is providing pharmacy benefits management to its insureds.

9. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.

10. "Utilization information" means de-identified information regarding the quantity of drug prescriptions dispensed to members of a health plan during a specified time period.

**26.1-27.1-02. Licensing.** A person may not perform or act as a pharmacy benefits manager in this state unless that person holds a certificate of registration as an administrator under chapter 26.1-27.

**26.1-27.1-03. Disclosure requirements.**

1. A pharmacy benefits manager shall disclose to the commissioner any ownership interest of any kind with:

   a. Any insurance company responsible for providing benefits directly or through reinsurance to any plan for which the pharmacy benefits manager provides services.

   b. Any parent company, subsidiary, or other organization that is related to the provision of pharmacy services, the provision of other prescription drug or device services, or a pharmaceutical manufacturer.

2. A pharmacy benefits manager shall notify the commissioner in writing within five business days of any material change in the pharmacy benefits manager's ownership.

**26.1-27.1-04. Prohibited practices.**

1. A pharmacy benefits manager shall comply with chapter 19-02.1 regarding the substitution of one prescription drug for another.

2. A pharmacy benefits manager may not require a pharmacist or pharmacy to participate in one contract in order to participate in another contract. The pharmacy benefits manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in a particular network if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.

**26.1-27.1-05. Contents of pharmacy benefits management agreement - Requirements.**

1. A pharmacy benefits manager shall offer to a covered entity options for the covered entity to contract for services that must include:

   a. A transaction fee without a sharing of a payment received by the pharmacy benefits manager;

   b. A combination of a transaction fee and a sharing of a payment received by the pharmacy benefits manager; or

   c. A transaction fee based on the covered entity receiving all the benefits of a payment received by the pharmacy benefits manager.

2. The agreement between the pharmacy benefits manager and the covered entity must include a provision allowing the covered entity to have audited the pharmacy benefits manager's books, accounts, and records, including de-identified utilization information, as necessary to confirm that the benefit of a payment received by the pharmacy benefits manager is being shared as required by the contract.

**26.1-27.1-06. Examination of insurer-covered entity.**

1. During an examination of a covered entity as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the covered entity and a pharmacy benefits manager and any related record to determine if the payment received by the pharmacy benefits manager which the covered entity received from the pharmacy benefits manager has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.

2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager received under any contract with a pharmacy benefits manager and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.

3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1.

**26.1-27.1-07. Rulemaking authority.** The commissioner shall adopt rules as necessary before implementation of this chapter.

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# HEALTHCARE NEWS

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## IN THIS ISSUE...



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# Reimbursement

## UB-04 Fee Schedule Changes for 2009

The following fee schedules have been established for Blue Cross Blue Shield of North Dakota (BCBSND) effective for services on or after January 1, 2009: UB-04 Inpatient DRG Rate Schedule, the Reference Lab list, Hospital Outpatient Fee Schedule, Home Health Fee Schedule, Anesthesia Fee Schedule, Transitional Care Unit (TCU), Swingbed, Inpatient Psych/Substance Abuse, Inpatient Rehab and Long Term Acute Care.

Payment is based on the lesser of charge or fee schedule amount for all outpatient services. Inpatient services are reimbursed at the fee schedule amount. These fee schedules are intended exclusively for the private use of BCBSND participating providers. They are considered confidential. Any other use or redistribution of these fee schedules without the written consent of BCBSND is prohibited.

BCBSND will continue to reimburse mid-tier and rural hospitals at 115% and 125% respectively for both the Hospital Outpatient and Home Health Fee Schedule rates. Specific product discounts or contractual arrangements that your facility may have with BCBSND are not reflected in the enclosed fee schedules.

Fee schedules contain several changes for 2009. In general, a 4% overall increase will be applied to all fee schedule rates with a few exceptions as noted below. Additional payment will be applied for behavioral services rendered in a residential treatment center to complete the transition of these rates.

The rate increases are applied after adjustments for budget neutrality are made to the DRGs, outpatient surgical rates, and other applicable fee schedules to accommodate for the relative weighting changes. Individual hospital impacts will differ depending on how the refinement of fee schedules affects each hospital's case mix.

The **4% increase does not apply to** Home Medical Equipment; Level I Partial Hospitalization Substance Abuse Services; Injectables, J-Codes and Related Pharmacy.

For a better understanding of the major reimbursement changes for 2009, the following details are provided.

1. DRGs - Inpatient stays will be reimbursed based on Grouper version 26.0 of the Medicare Severity Diagnostic Related Groups (MS-DRGs) as employed in CMS's Inpatient Prospective Payment System. 2009 CMS MS-DRG weights will be used to set reimbursement relative to each DRG, with the following exceptions:
   - The maternity and newborn weights will continue to be based on North Dakota's provider charges. The base rate has been established through a budget neutral calculation by applying the new grouper to historical claims and reassigning to the appropriate MS-DRG.
   - An amount based on average organ acquisition cost has been added to the DRG rate for MS-DRGs 8 (simultaneous pancreas/kidney transplant), 10 (pancreas transplant), and 652 (kidney transplant) in lieu of adding the specific cost associated with each organ per individual case.
2. Inpatient Outlier Threshold - The inpatient outlier fixed dollar threshold will decrease from $36,621 to $35,652.
3. Long-Term Acute Care - Long-term acute care stays will be grouped based on the new MS-DRG grouper. The rates will be recalibrated based on Medicare's 2009 per diem rates.
4. Swingbed/Transitional Care Unit (TCU) - Swingbed and TCU rates will continue to be based on an all-inclusive per diem rate and will reflect the 2009 Resource Utilization Group (RUG) average for their respective category.
5. Reimbursement for therapeutic radiology technical services, physical therapy, occupational therapy, speech therapy services and mammography outpatient services remain standardized for hospital-based and freestanding entities. The changes in the 2009 fee schedule amounts are due to the updating for the one-year lag of the 2008 RVUs and the across-the-board increase of 4%.
6. Reimbursement for diagnostic radiology codes with an APC status indicator of "S" continues to be based on 125-150% of the technical component of the 2008 BCBSND Physician Payment Schedule (PPS). Radiology codes with an APC status indicator of "X" continue to be reimbursed at 125% of the PPS reimbursement. Changes in the 2009 fee schedule amounts are due to the updating for the one-year lag of the 2008 RVUs and the across-the-board increase of 4%.
7. PET Scans - PET scan rates will be based on CMS's proposed 2009 APC amount. The radiopharmaceutical will continue to receive separate payment.
8. Outpatient Lab - Codes based on Medicare's Clinical Lab Fee Schedule will be paid at approximately 205% of the 2008 Medicare rate, after the 4% increase is applied.
9. Reference Lab - The reference lab list is composed of codes that will be reimbursed at 100% of charges when performed at a reference lab and billed with modifier 90. CPT® codes 87187, 88155, 88312 and 88313 will be added to the list for 2009. Providers are encouraged to append modifier 90 to procedures sent to a reference lab. Providers should bill charges imposed by the reference lab for all tests sent to a reference lab even if they are not currently on the reference lab list.

10. Outpatient Surgical Rates - The hospital outpatient surgical rates are based on Medicare's proposed 2009 OPPS APCs. The surgical rates will be recalibrated using Medicare's APCs prior to wage index adjustments.
11. Significant Outpatient Surgical Procedures - The following surgical procedures have been increased to a rate halfway between the 2009 MS-DRG rate and the proposed 2009 outpatient rate.

| CPT® Code | Description | CPT® Code | Description |
|---|---|---|---|
| 33240 | Insertion of single/dual pulse generator | 63005 | Laminectomy, 1 or 2 segments, lumbar |
| 33249 | Insert/Reposition leads, generator | 63030 | Hemilaminectomy, 1 interspace, lumbar |
| 43280 | Laparoscopy, surgical, esophagogastric fundoplasty | 63267 | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar |
| 43770 | Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device | 64590 | Insert/replace neurostimulator generator or receiver |
| 63003 | Laminectomy, 1 or 2 segments, thoracic | | |

12. Home Medical Equipment - Home Medical Equipment rates will continue to be based on 110% of the 2009 Medicare Fee Schedule.
13. Psychiatric Facility Fee - Fee schedule amounts on the Hospital Outpatient Fee Schedule will represent a facility fee for the psychiatric CPT® codes 90801-90899, with the exception of Electroconvulsive Therapy (90870). The outpatient rates will be based on the site of service (SOS) differential from the Physician Payment Schedule (PPS) if one is available. Codes without a SOS differential will be based on APCs. Therefore, payment will be for the overhead costs of the facility only. The facility fee for outpatient services should continue to be billed on the UB-04 claim form. The corresponding professional psychiatric services associated with those outpatient services must be submitted on the CMS-1500 claim form. Also effective January 1, 2009, BCBSND will only use claims submitted on the CMS-1500 to accumulate the member's hourly benefit maximum for these psychiatric services.
14. Dialysis Support Services - Reimbursement for dialysis services (i.e. Hemodialysis, Continuous Ambulatory Peritoneal Dialysis & Continuous Cycling Peritoneal Dialysis) will include any support service provided. Charges billed separately with support services revenue codes 0825, 0835, 0845 or 0855 will be denied as included in the dialysis rate.
15. Chemotherapy Administration - CPT® codes 96401-96549 (with the exception of 96521, 96522 and 96523) will only be allowed when billed for administration of infliximab (J1745), decitabine (J0894) or a chemotherapy drug (J9001-J9999). Claims submitted with a chemotherapy administration code, but without one of these drugs, will be held and reviewed individually.

CPT®/HCPCS codes that are not on the fee schedule are considered to be "by report." They are manually reviewed and payment is determined on an individual basis.

The existence of a procedure code on these fee schedules is not a guarantee the code is valid or covered. These fee schedules may contain procedure codes that have been replaced by other HCPCS or CPT® codes. Edits in BCBSND's system check for procedure validity and will reject invalid codes. Some codes may represent services for which benefits are not available.

BCBSND Participating RURAL Hospitals

| | |
|---|---|
| Ashley Medical Center | Ashley |
| Carrington Health Center | Carrington |
| Cavalier County Memorial Hospital | Langdon |
| Community Memorial Hospital | Turtle Lake |
| Cooperstown Medical Center | Cooperstown |
| First Care Health Center | Park River |
| Fort Yates Hospital | Fort Yates |
| Garrison Memorial Hospital | Garrison |
| Heart of America Medical Center | Rugby |
| Jacobson Memorial Hospital | Elgin |
| Kenmare Community Hospital | Kenmare |
| Kittson Memorial Hospital | Hallock |
| Linton Hospital | Linton |
| Lisbon Medical Center | Lisbon |
| McKenzie County Memorial Hospital | Watford City |
| Medical Center - Hospital | Hillsboro |
| Mercy Hospital | Valley City |
| Mercy Hospital | Devils Lake |
| Mountrail County Medical Center | Stanley |
| Nelson County Health System | McVille |
| Northwood Deaconess Health Center | Northwood |
| Oakes Community Hospital | Oakes |
| Pembina County Memorial Hospital | Cavalier |
| Presentation Medical Center | Rolla |
| Quentin Burdick Comp Facility | Belcourt |
| Richardton Health Center | Richardton |
| Riverview Healthcare Association | Crookston |
| Sakakawea Medical Center | Hazen |
| St. Aloisius Medical Center | Harvey |

| | |
|---|---|
| St. Andrew's Health Center | Bottineau |
| St. Luke's Hospital | Crosby |
| Southwest Health Care Services | Bowman |
| Tioga Medical Center | Tioga |
| [redacted]ner County Medical Center | Cando |
| [redacted]n Hospital | Mayville |
| [redacted]nity Hospital | Grafton |
| West River Regional Medical Center | Hettinger |
| Wishek Community Hospital | Wishek |

BCBSND Participating MID-TIER Hospitals

| | |
|---|---|
| Jamestown Hospital | Jamestown |
| St. Joseph's Hospital | Dickinson |
| Mercy Hospital | Williston |

## CMS-1500 Fee Schedules Changes for 2009

The following fee schedules have been established for Blue Cross Blue Shield of North Dakota (BCBSND) effective for services performed on or after January 1, 2009: Physician Payment Schedule (PPS), Clinical Laboratory Fee Schedule, Ambulatory Surgery Center (ASC) Fee Schedule, Anesthesia Fee Schedule, Injectables/Other Pharmacy Fee Schedule, Home Medical Equipment (HME) Fee Schedule. The Reference Laboratory and Assistant at Surgery lists have also been updated.

Payment is based on the lesser of charge or fee schedule amount. Specific product discounts or contractual arrangements that you may have with BCBSND are not [redacted]ected in the fee schedules. These fee schedules [redacted]intended exclusively for the private use of BCBSND participating providers. They are considered confidential. Any other use or redistribution of these fee schedules without the written consent of BCBSND is prohibited.

The fee schedules contain several changes for 2009. In general, a 4% overall increase will be applied to all fee schedule rates except the Injectables/Other Pharmacy Fee Schedule and HME Fee Schedule. Additional increases will be applied to preventive medicine services to continue their transition to full relative value.

BCBSND bases the PPS on the Medicare Resource Based Relative Value Scale and Year 2009 Transitional Relative Value Units (RVUs) as published November 19, 2008 in the *Federal Register*.[1] The new conversion factor was calculated by neutralizing the 2008 conversion factor for the effects of the changes in RVUs and increased by 4%.

The PPS indicates the rates reimbursable to physicians. In some instances, rates applied to allied providers are based on a percentage of the rate indicated on the PPS.

For a better understanding of the major reimbursement changes for 2009, the following details are provided.

1. Preventive Medicine Services (CPT® codes 99381 - 99397) - Currently, preventive medicine services are reimbursed based on 75% of the RVU. Beginning January 1, 2009, BCBSND will base its payment on 87.5% of Medicare's RVU. This change was calculated outside of the conversion factor calculation.
2. Outpatient Lab - Codes based on Medicare's Clinical Lab Fee Schedule will be paid at approximately 205% of the 2008 Medicare rate, after the 4% increase is applied.
3. Reference Lab - The reference lab list is composed of codes that will be reimbursed at 100% of charges when performed at a reference lab and billed with modifier 90. CPT® codes 87187, 88155, 88312 and 88313 will be added to the list for 2009. Providers are encouraged to append modifier 90 to procedures sent to a reference lab. Providers should bill charges imposed by the reference lab for all tests sent to a reference lab even if they are not currently on the reference lab list.
4. ASC Facility Fees - Facility fees for surgical procedures performed in an ASC will be based on Medicare's proposed 2008 OPPS APCs with a few exceptions[2]. The rates will be recalibrated using Medicare's APCs prior to wage index adjustments.
5. Significant ASC Surgical Procedures - The following surgical procedures have been increased to a rate halfway between the 2009 MS-DRG rate and the proposed 2009 ASC rate.

| CPT® Code | Description |
|---|---|
| 43770 | Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device |
| 63030 | Hemilaminectomy, 1 interspace, lumbar |
| 64590 | Insert/replace neurostimulator generator or receiver |

6. Chemotherapy Administration - CPT® codes 96401-96549 (with the exception of 96521, 96522 and 96523) will only be allowed when billed for administration of infliximab (J1745), decitabine (J0894) or a chemotherapy drug (J9001-J9999). Claims submitted with a chemotherapy administration code, but without one of these drugs, will be held and reviewed individually.
7. Chiropractic Manipulative Treatment - Effective

[1] Therapeutic radiology codes are based on BCBSND's conversion factor. The technical portion is reimbursed at 125 percent of the RVU multiplied by the conversion factor. The global reimbursement is the sum of the technical and professional [redacted]onents. Preventive medicine is based on 7/8 of the RVU and [redacted]unization administration is based on 3/4 of the RVU.

[2] Certain office-based procedures are rated based either on the PPS site of service differential or the 2009 final ASC APC amount. A few significant procedures are priced based on the mid-point of the 2009 BCBSND DRG rate and the 2009 proposed Hospital Outpatient rate.

January 1, 2009, when an extraspinal region manipulation (98943) is performed on the same patient on the same day as a spinal manipulation (98940, 98941, 98942), reimbursement for the extraspinal manipulation will not be reduced. Reimbursement will be based on the full PPS amount for spinal and extraspinal manipulations when billed together.

8. Home Medical Equipment - Home Medical Equipment rates will continue to be based on 110% of the 2009 Medicare Fee Schedule. *Note: Effective January 1, 2009, K0009 (Other manual wheelchair/base) will be considered "By Report" and will be reviewed and paid on an individual basis. Please disregard the dollar amount listed on the fee schedule.*

The existence of a procedure code on these fee schedules is not a guarantee the code is valid or covered. These fee schedules may contain procedure codes that have been replaced by other HCPCS or CPT® codes. Edits in BCBSND's system check for procedure validity and will reject invalid codes. Some codes may represent services for which benefits are not available.

## Outpatient Surgery

The reimbursement process for outpatient surgical claims is described by a surgical roll-up. The roll-up applies to claims with surgical procedures. The surgical procedures include the following and are reviewed quarterly.

10021-69999

Added: 20696, 20697, 22856, 22861, 22864, 27027, 27057, 35535, 35570, 35632, 35633, 35634, 41512, 41530, 43273, 43279, 46930, 49652, 49653, 49654, 49655, 49656, 49657, 55706, 61796, 61797, 61798, 61799, 61800, 62267, 63620, 63621, 64455, 64632, 65756, 65757, 0193T, 0195T, 0196T, G0412, G0413, G0414, G0415, S2118, S2270

**Excludes:** 19030, 19290, 19291, 20501, 21116, 23350, 24220, 25246, 27093, 27095, 27370, 27648, 31715, 36005, 36415, 36430, 36440, 36450, 36460, 36591, 36592, 38200, 38207, 38208, 38209, 38790, 42550, 47500, 47505, 49400, 49427, 50394, 50684, 50690, 51600, 51610, 51701, 51702, 51798, 58340, 59020, 59025, 62284, 62290, 62291, 68850

- 90870 - 90871 (electroshock therapy)
- 92973-92990, 92995-92998 and 93505
- 93501 - 93556 (cardiac cath)
- 93600 - 93662 (EPS)
- HCPCS codes that are surgical in nature
- Category III CPT® codes that are surgical in nature

If one or more of the codes listed above are billed on an outpatient claim, charges on specific revenue codes associated with the surgery will be added together for the surgical roll-up. The total of all charges on all of the specific revenue codes is compared to the fee schedule rate for the surgical procedure(s) present on the claim. Surgical procedures are reimbursed at full, half, half, etc. Reimbursement is the lesser of the charges or the total fee schedule amount. Any additional charges not included in the rolled-up service are reimbursed at their appropriate rate dependent on the type of service. Examples of charges that would not apply the surgical roll-up are lab, radiology, home medical equipment and therapy services which all require appropriate HCPCS and revenue code(s).

The following are the revenue codes that roll-up (this list is reviewed and updated annually):

| | | | | | | |
|---|---|---|---|---|---|---|
| 0250 | 0263 | 0361 | 0490 | 0520 | 0700 | 0901 |
| 0251 | 0264 | 0362 | 0499 | 0521 | 0709 | 0912 |
| 0252 | 0269 | 0367 | 0510 | 0522 | 0710 | 0913 |
| 0253 | 0270 | 0369 | 0511 | 0523 | 0719 | 0920 |
| 0256 | 0271 | 0370 | 0512 | 0526 | 0750 | 0929 |
| 0257 | 0272 | 0371 | 0513 | 0529 | 0759 | 0940 |
| 0258 | 0275 | 0372 | 0514 | 0621 | 0760 | 0949 |
| 0259 | 0276 | 0374 | 0515 | 0622 | 0761 | |
| 0260 | 0278* | 0379 | 0516 | 0623 | 0762 | |
| 0261 | 0279 | 0481 | 0517 | 0636** | 0769 | |
| 0262 | 0360 | 0489 | 0519 | 0637 | 0790 | |

*See specific Level II HCPCS listed in HealthCare News #301 that will not be included in the surgical allowance when billed on 0278.

**See specific Level II HCPCS listed in HealthCare News #301 that will not be included in the surgical allowance when billed on 0636.

Codes that are considered surgical should be submitted on the same claim for the same stay. Units must always be one (1). Modifiers should be used if different sites need to be identified; however, surgical procedures performed bilaterally must be submitted as two separate line items to receive the correct reimbursement. Modifier 50 may be appended to one of the lines but a bilateral procedure cannot be billed as only one line with modifier 50. Use of modifier 73 (discontinued procedure prior to anesthesia) will result in a 50 percent reduction to the fee schedule amount for the procedure.

The presence of a code on the listing of surgical procedures does not indicate coverage. Any medical policies and benefits continue to apply.

## HCPCS Billed on Revenue Code 0636 Not Included in the Surgical Allowance

Certain drugs and pharmaceuticals billed with revenue code 0636 and a procedure that is considered surgical are included in the surgical allowance. The following are the HCPCS Level II codes that are not included in the surgical allowance and will be considered for additional reimbursement when billed with revenue code 0636.

The fee schedule for these codes is based on the ASP (average sales price) or AWP (average wholesale

price), which are updated at least quarterly. The codes excluded from the surgical allowance will be reviewed and updated annually.

**Codes in bold are new for 2009:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted]284 | A9545 | C9121 | **J0641** | J1568 | **J2785** | J7306 | J8600 | J9170 | J9305 | Q4109 | S0142 |
| [redacted]650 | A9546 | C9232 | J0706 | J1569 | J2791 | J7307 | J8610 | J9175 | J9310 | Q4110 | S0143 |
| 90661 | A9547 | C9233 | J0735 | J1570 | J2794 | J7308 | J8700 | J9178 | J9320 | Q4111 | S0145 |
| 90662 | A9548 | C9234 | J0795 | J1571 | J2805 | J7310 | **J8705** | J9181 | **J9330** | Q4112 | S0146 |
| 90663 | A9550 | C9235 | J0850 | J1572 | J2820 | J7311 | J8999 | J9182 | J9340 | Q4113 | S0155 |
| 90681 | A9551 | C9237 | J0881 | J1573 | J2850 | J7321 | J9000 | J9185 | J9350 | Q4114 | S0156 |
| 90696 | A9552 | C9238 | J0882 | J1595 | J2940 | J7322 | J9001 | J9190 | J9355 | Q9951 | S0157 |
| A4641 | A9553 | C9239 | J0885 | J1600 | J2941 | J7323 | J9010 | J9200 | J9357 | Q9953 | S0170 |
| A4642 | A9554 | C9240 | J0886 | J1640 | J2993 | J7324 | J9015 | J9201 | J9360 | Q9954 | S0172 |
| A4802 | A9555 | **C9245** | J0894 | J1670 | J2995 | J7330 | J9017 | J9202 | J9370 | Q9955 | S0175 |
| A9500 | A9556 | **C9248** | J1055 | J1675 | J2997 | J7340 | J9020 | J9206 | J9375 | Q9956 | S0176 |
| A9501 | A9557 | C9351 | J1056 | J1740 | J3100 | J7341 | J9025 | **J9207** | J9380 | Q9957 | S0177 |
| A9502 | A9558 | C9352 | J1162 | J1743 | **J3101** | J7346 | J9027 | J9208 | J9390 | Q9958 | S0178 |
| A9503 | A9559 | C9353 | J1245 | J1745 | J3110 | J7348 | J9031 | J9209 | J9395 | Q9959 | S0179 |
| A9504 | A9560 | C9354 | **J1267** | J1751 | J3243 | J7349 | **J9033** | J9211 | J9600 | Q9960 | S0182 |
| A9505 | A9561 | C9355 | J1270 | J1752 | **J3300** | J7500 | J9035 | J9212 | J9999 | Q9961 | S0183 |
| A9507 | A9562 | C9727 | J1300 | J1756 | J3305 | J7501 | J9040 | J9213 | P9041 | Q9962 | S0187 |
| A9508 | A9563 | J0128 | J1324 | J1825 | J3355 | J7502 | J9041 | J9214 | P9043 | Q9963 | S0189 |
| A9509 | A9564 | J0129 | J1335 | J1830 | J3365 | J7504 | J9045 | J9215 | P9045 | Q9964 | S0190 |
| A9510 | A9565 | J0130 | J1430 | **J1930** | J3396 | J7505 | J9050 | J9216 | P9046 | Q9965 | S0191 |
| A9512 | A9566 | J0132 | J1440 | J1931 | J3471 | J7507 | J9055 | J9217 | P9047 | Q9966 | S0195 |
| A9516 | A9567 | J0135 | J1441 | J1945 | J3472 | J7511 | J9060 | J9218 | P9048 | Q9967 | S0197 |
| A9517 | A9568 | J0150 | J1451 | J1950 | J3473 | J7513 | J9062 | J9219 | Q0166 | S0014 | S5000 |
| A9521 | A9569 | J0180 | J1452 | **J1953** | J3485 | J7515 | J9065 | J9225 | Q0167 | S0023 | S5001 |
| A9524 | A9570 | J0207 | **J1453** | J1955 | J3486 | J7516 | J9070 | J9226 | Q0168 | S0028 | S5014 |
| A9526 | A9571 | J0220 | J1457 | J2170 | J3487 | J7520 | J9080 | J9230 | Q0515 | S0078 | S5560 |
| [redacted]9527 | A9572 | J0270 | J1458 | J2248 | J3520 | J7525 | J9090 | J9245 | Q2009 | S0080 | S5561 |
| [redacted]528 | A9576 | J0275 | **J1459** | J2260 | **J7186** | J7599 | J9091 | J9250 | Q2017 | S0088 | S5565 |
| [redacted]529 | A9577 | J0282 | J1470 | J2323 | J7187 | J7605 | J9092 | J9260 | Q3025 | S0090 | S5566 |
| A9530 | A9578 | J0282 | J1480 | J2355 | J7189 | **J7606** | J9093 | J9261 | Q3026 | S0104 | S5570 |
| A9531 | A9579 | J0348 | J1490 | J2357 | J7190 | J7639 | J9094 | J9263 | Q4080 | S0106 | S5571 |
| A9532 | A9600 | J0350 | J1500 | J2425 | J7191 | J7640 | J9095 | J9264 | Q4081 | S0108 | |
| A9535 | A9605 | J0364 | J1510 | J2430 | J7192 | J7674 | J9096 | J9265 | Q4082 | S0122 | |
| A9536 | A9698 | J0400 | J1520 | J2503 | J7193 | J7676 | J9097 | J9266 | Q4100 | S0126 | |
| A9537 | A9699 | J0476 | J1530 | J2504 | J7194 | J7682 | J9100 | J9268 | Q4101 | S0128 | |
| A9538 | A9700 | J0480 | J1540 | J2505 | J7195 | J8501 | J9110 | J9270 | Q4102 | S0132 | |
| A9539 | C2634 | J0583 | J1550 | J2513 | J7197 | J8510 | J9120 | J9280 | Q4103 | S0136 | |
| A9540 | C2635 | J0585 | J1560 | J2545 | J7198 | J8515 | J9130 | J9290 | Q4104 | S0137 | |
| A9541 | C2636 | J0587 | J1561 | J2597 | J7199 | J8520 | J9140 | J9291 | Q4105 | S0138 | |
| A9542 | C2637 | J0594 | J1562 | J2724 | J7300 | J8530 | J9150 | J9293 | Q4106 | S0139 | |
| A9543 | C9003 | J0595 | J1565 | J2778 | J7302 | J8560 | J9151 | J9300 | Q4107 | S0140 | |
| A9544 | C9113 | J0640 | J1566 | J2783 | J7304 | J8565 | J9160 | J9303 | Q4108 | S0141 | |

## Supplies/Devices/Implants Used During Outpatient or ASC Surgery

The 2009 Blue Cross Blue Shield of North Dakota Uniform Surgical Fee Schedule (USFS) rating methodology is based on Medicare's proposed 2009 Hospital Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs). The 2009 USFS rates continue to include an amount for most devices, implants and supplies. Some supplies/devices/implants will continue to be paid in addition to the surgical allowance. These supplies/devices/implants will be reimbursed based on the established fee schedule amount or the invoice plus 20% if it is a non-rated code. These items must be identified by the appropriate HCPCS Level II code.

**CMS-1500 Providers:**

[redacted]tinue to bill the appropriate HCPCS Level II code for any supplies/devices/implants. Any C codes that are billed are not on the list below, will be returned to the provider.

**UB-04 Providers:**

Devices/implants/supplies must be billed with revenue code 0278 (Supply/Implants). Although HCPCS are not required on revenue code 0278, providers should bill the appropriate HCPCS for items identified below as separately payable. Routine types of supplies should continue to be billed with revenue codes 0270 (Med-Surg Supplies) or 0272 (Sterile Supply).

Listed below are the items that will be paid in addition to the surgical allowance for service dates on or after January 1, 2009. **The codes in bold have recently been added for 2009 service dates:**

| | |
|---|---|
| C1716 | Brachytx, non-str, Gold-198 |
| C1717 | Brachytx, non-str,HDR Ir-192 |
| C1719 | Brachytx, NS, Non-HDRIr-192 |
| C2616 | Brachytx, non-str,Yttrium-90 |
| C2634 | Brachytx, non-str, HA, I-125 |
| C2635 | Brachytx, non-str, HA, P-103 |
| C2636 | Brachy linear, non-str,P-103 |
| C2637 | Brachy,non-str,Ytterbium-169 |
| C2638 | Brachytx, stranded, I-125 |
| C2639 | Brachytx, non-stranded,I-125 |
| C2640 | Brachytx, stranded, P-103 |
| C2641 | Brachytx, non-stranded,P-103 |
| C2642 | Brachytx, stranded, C-131 |
| C2643 | Brachytx, non-stranded,C-131 |
| [illegible]2698 | Brachytx, stranded, NOS |
| [illegible]2699 | Brachytx, non-stranded, NOS |
| C9354 | Veritas collagen matrix, cm2 |
| C9355 | Neuromatrix nerve cuff, cm |
| **C9356** | **TenoGlide tendon prot, cm2** |
| **C9358** | **SurgiMend, 0.5cm2** |
| **C9359** | **Implant, bone void filler** |
| D3460 | Endodontic endosseous implan |
| J7306 | Levonorgestrel implant sys |
| J7310 | Ganciclovir long act implant |
| J7311 | Fluocinolone acetonide implt |
| J7340 | Metabolic active D/E tissue |
| J7342 | Metabolically active tissue |
| J7343 | Nonmetabolic act d/e tissue |
| J7344 | Nonmetabolic active tissue |
| J7346 | Injectable human tissue |
| J9202 | Goserelin acetate implant |
| L8619 | Replace cochlear processor |
| L8681 | Pt prgrm for implt neurostim |
| L8683 | Radiofq trsmtr for implt neu |
| L8684 | Radiof trsmtr implt scrl neu |
| L8689 | External recharg sys intern |
| [illegible]8695 | External recharg sys extern |
| V2785 | Corneal tissue processing |
| V5095 | Implant mid ear hearing pros |

# Medical Policy

## Retired Medical Policies

The following medical policies were retired in 2008:

Ophthalmoscopy
Visual Field
Therapeutic Radiology
Functional Electrical Stimulation for Ambulation
Foot Orthotics
Computer Aided Mammography
Lung Volume Reduction Surgery
Tissue Pressure Measurement
Noninvasive Helicobacter Pylori Testing
Fetal Fibronectin Enzyme Immunoassay
Automatic Implantable Cardioverter Defibrillator
Cardiovascular Stress Test
Diabetic Foot Care
Smallpox
Unna Boot

Blue Cross Blue Shield of North Dakota may retire medical policies for reasons including, but not limited to, lack of evidence of current problems or outdated technology resulting in minimal claims volume. Retired medical policies will no longer be scheduled for review unless misuse or technological changes are identified.

Providers who have complied or adjusted their billing and coding practices to correspond to the directives in the medical policy should be careful in deviating from those practices because the medical policy is retired. The directions of the medical policy may still be helpful in assessing medical necessity. The provider is responsible for correct claim submission whether or not a medical policy is in place.

Retired medical policies are available at www.THORConnect.org.

# BlueCard

## Request for Medical Information

Effective January 15, 2009, providers will have 10 business days to send Blue Cross Blue Shield of North Dakota the medical information requested for an internal review of BlueCard claims for out of state members. If the information is not received after 10 business days, we will call the provider and request the information to be faxed. Providers will have an additional 4 days to fax the information. If the information is not received within this timeframe, the claim will be deleted and returned to the provider.

# Chiropractic

## Chiropractic Manipulative Treatment (CMT) Coding

Claims for Chiropractic Manipulative Treatment (CMT) services must have the appropriate supportive ICD-9-CM diagnosis codes to be accepted for processing. If the CMT code is not supported by proper coding, the claim will be returned to the provider for correction.

CPT® codes 98940-98943 are used to identify procedures related to CMT. These procedures use high-velocity, short-lever, low-amplitude thrust by hand or instrument to remove structural dysfunction in joints and muscles that may be associated with neurologic or mechanical dysfunction of the spinal joints and surrounding tissue. These procedures are specifically and primarily used by chiropractors to mobilize, adjust, manipulate, apply traction, massage, stimulate or otherwise influence the spine and paraspinal tissues to affect the patient's health.

Chiropractors must select the appropriate CPT® code to describe the manipulative service provided during a visit. The procedure code descriptors are based on the number of body regions receiving manipulation.

**Chiropractic Manipulative Treatment Codes**

| CPT® | |
|---|---|
| 98940 | Chiropractic manipulative treatment (CMT); spinal, one to two regions |
| 98941 | Chiropractic manipulative treatment (CMT); spinal, three to four regions |
| 98942 | Chiropractic manipulative treatment (CMT); spinal, five regions |
| 98943 | Chiropractic manipulative treatment (CMT); extraspinal, one or more regions |

**Spinal Manipulative Treatment body regions include:**

| | |
|---|---|
| Cervical | All manipulations performed to the atlanto-occipital joint; C1 through C7. |
| Thoracic | All manipulations performed to T1 through T12, including the posterior ribs (costotransverse and costovertebral junctions). |
| Lumbar | All manipulations performed to L1 through L5. |
| Sacral | All manipulations performed to the sacrum, including the sacroccygeal junction. |
| Pelvic | All manipulations performed to the sacroiliac joint and other pelvic articulations. |

Note: Each CPT® code reflects a specific number of regions, regardless of how many manipulations are performed in that region.

For example:

Chiropractic manipulation applied to C3 and C5 during the same visit represent treatment to only one region (cervical) and should be reported with CPT® code 98940.

**Extraspinal Manipulative Treatment**

Manipulative treatment of the appendicular skeleton should be billed with CPT® code 98943 regardless of how many individual extraspinal manipulations are performed. CPT® code 98943 can be billed alone or in conjunction with a spinal CMT code. When billed with a spinal CMT code, a 51 modifier (98943-51) must be added to identify a multiple procedure.

**Extraspinal Manipulative Treatment body regions include:**

| | |
|---|---|
| Head | All manipulations performed to the head, including the TMJ, excluding the atlanto-occipital joint. |
| Lower extremities | All manipulations performed to the hip, leg, knee, ankle and foot. |
| Upper extremities | All manipulations performed to the shoulder, arm, elbow, wrist and hand. |
| Rib cage | All manipulations performed to the anterior rib cage, including the costosternal junction. |
| Abdomen | All manipulations performed to the abdominal area. |

**Components of Chiropractic Manipulation Treatment codes**

The establishment of the CMT code includes a "work per unit of time" which is reflected in the Relative Value Units

(RVUs). The RVUs take into consideration the work expense (work unit), practice expense, and malpractice expense. The reimbursement amount is calculated by multiplying the RVU times the conversion factor. The conversion factor is a base dollar amount that applies to all physician codes with RVUs. Since RVUs can change from year to year, the conversion factor is recalculated annually to remain budget neutral for total physician payments.

**CMT Components**

| | |
|---|---|
| Pre-Service | A brief evaluation of the patient documentation and chart review, imaging review, test interpretation and care planning |
| Intra-Service | Treatment applied Pre-manipulation (e.g., palpation, etc.) Manipulation, Post-manipulation (e.g., assessment, etc.) |
| Post-Service | Chart entry and documentation, including subjective, objective, assessment, plan consultation reporting |

**ICD-9-CM Coding**

All CMT codes must have a supporting ICD-9-CM diagnosis code to justify the level of care provided. If the proper diagnosis code is not provided to support each CMT code, claims will be returned to the provider for correction. See below example:

For CPT® 98941, there must be at least three ICD-9-CM codes indicating the three different regions treated.

# Claims Processing

## Medical Records Cover Sheet

A Medical Records Cover Sheet is now available at www.THORConnect.org. Providers should attach this cover sheet to medical records requested by Blue Cross Blue Shield of North Dakota to assist in the processing and payment of a submitted claim that has been denied or pended for medical review. This form should not be used when submitting requests for changes to a previously submitted claim that requires medical documentiation; the Request for Claim Adjustment form should be used in these situations.

The Medical Records Cover Sheet, along with the medical records and original request for medical records (if possible), can be faxed to Provider Service at 701-277-2132 or mailed to Attention: Provider Service, Blue Cross Blue Shield of North Dakota, 4510 13th Ave S, Fargo, ND 58121.

# Coding and Billing

## Outpatient Chemotherapy/Therapeutic Infusion Administration - Institutional

***Effective for services on or after January 1, 2009***

The American Medical Association (AMA) has re-categorized and re-numbered the CPT® codes that identify hydration, diagnostic and therapeutic injections and infusions to align more closely with codes used for chemotherapy administration for calendar year 2009. These new codes for hydration, diagnostic and therapeutic injections and infusions continue to follow the same guidelines as the previous series of codes. CPT® 2009 provides a great deal of parenthetical information that is important to use when billing these services. The following guidelines apply to use of these codes within the facility setting.

1. CPT® specifically notes that new code 96376 is for use by the **facility only.** This code should not be billed by the physician on the CMS-1500. This code may not be reported with less than a 30-minute interval for sequential intravenous push administration of the same drug.
2. According to CPT®, when these codes are reported **by the facility,** there are certain instructions that apply. The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic and diagnostic services which are primary to hydration services. Infusions are primary to pushes, which are primary to injections.
3. The chemotherapy administration codes (96401 - 96549) are for use with the parenteral administration of non-radionuclide anti-neoplastic drugs and anti-neoplastic agents provided for treatment of noncancer diagnoses. They may also be used for substances such as certain monoclonal antibody agents and other biologic response modifiers. These highly complex substances require additional physician and staff monitoring due to the higher incidence and severity of adverse reactions. Beginning January 1, 2009, only certain pharmaceuticals will be allowed to be used with the chemotherapy administration codes. These include J9001-J9999, J1745 or J0894. Chemotherapy administration codes are not used for intravenous immunoglobulin (IVIG). IVIG is billed under therapeutic/diagnosis infusions.
4. A separate amount will be reimbursed for "each additional hour" as services will not be reimbursed on

a bundled "per encounter" rate. It remains important to correctly identify the units for these services.

5. To bill "each additional hour", a minimum of 31 additional minutes of services must be provided. Time units are calculated based on how long the fluid is actually infusing into the patient. Time ends when the fluids have infused. Documentation within the medical record should substantiate start and stop times for the services. An infusion of 15 minutes or less should be reported using a "push" code.
6. There is only one "initial" drug administration code per encounter. The only exceptions to this are if the protocol requires that two separate IV sites must be utilized, or if the patient comes back for a second encounter on the same date of service. These services would be identified with modifier 59. Medical documentation must justify the use of the modifier.
7. An intravenous or intra-arterial push is defined as:
   - An injection administered by a health care professional who is continuously present to administer the injection and observe the patient OR
   - An infusion of 15 minutes or less. An infusion of 15 minutes or less should be reported using a "push" code.
8. An IV line that only provides hydration, and is considered an integral part of chemotherapy or drug administration, is not separately reportable. This service is included in chemotherapy or other therapeutic administration codes.
9. Hydration codes are intended to report IV infusions of pre-packaged fluid and/or electrolytes, but should not be used to report infusion of drugs or other substances.
10. Code 96367 (additional sequential infusion, up to 1 hour) is used to report the infusion of a second or subsequent drug after the initial drug. This must be a sequential infusion - not a concurrent infusion. 96367 is reported once per drug.
11. Code 96368 identifies a concurrent infusion. It is an add-on code and must be listed separately in addition to the code for the primary procedure.
    a. A concurrent infusion is when multiple infusions are provided simultaneously through the same intravenous line.
    b. Multiple substances mixed in one bag are considered to be one infusion.
    c. The concurrent infusion code can only be billed once per day.
    d. This code should not be used for chemotherapy infusions - it is used to report therapeutic/diagnostic infusions only.
    e. The concurrent infusion code will not be reimbursed separately. It will be bundled into other services.
12. Code 96523 identifies a port flush and should be used when a patient comes only to have their port flushed with saline. This code should not be reported if any other service related to the port (i.e. lab draw or other infusion) is performed that day and will be reimbursed when it is the only service provided.
13. Services such as the use of local anesthesia, IV start, access to indwelling IV (a subcutaneous catheter or port), a flush at the conclusion of an infusion, standard tubing, syringes and supplies are included in the payment for the drug administration service. These services should not be billed separately.
14. All providers, including Critical Access Hospitals, will use these codes to identify infusion services.
15. If the same drug is being given in multiple pushes, only one unit can be billed. An additional IV push can be billed for each new substance/drug.
16. These codes should not be submitted for infusions given during the course of an outpatient surgical procedure. IV infusions during surgery and recovery are considered part of the surgery and are included in the outpatient surgical roll-up.
17. If a patient is hospitalized during the course of the outpatient chemotherapy, outpatient claims must be split so they do not overlap the inpatient stay.
18. Line item service dates are required on these types of claims.

The following CPT® codes are available for services in the outpatient hospital setting. Codes in bold print identify initial services. ("+" indicates add-on code)

| Hydration Administration Codes | | | |
|---|---|---|---|
| 2009 Code | 2008 Code | Definition | Units |
| **96360** | 90760 | Intravenous infusion, hydration; **initial**, 31 minutes to 1 hour | 1 |
| +96361 | 90761 | each additional hour (List separately in addition to code for primary procedure) | Multiple |

| Therapeutic, Prophylactic, and Diagnostic Injections and Infusions | | | |
|---|---|---|---|
| 2009 Code | 2008 Code | Definition | Units |
| **96365** | 90765 | Intravenous infusion, for therapy, prophylaxis, or diagnosis; **initial**, up to 1 hour | 1 |
| +96366 | 90766 | each additional hour (List separately in addition to code for primary procedure) | Multiple |
| +96367 | 90767 | additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure) | Multiple |
| +96368 | 90768 | concurrent infusion (List separately in addition to code for primary procedure) | Bundled into other payment |
| **96369** | 90769 | Subcutaneous infusion for therapy or prophylaxis; **initial**, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s) | 1 |
| +96370 | 90770 | each additional hour (List separately in addition to code for primary procedure) | Multiple |
| +96371 | 90771 | additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure) | Multiple |
| 96372 | 90772 | Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular | Multiple |
| 96373 | 90773 | intra-arterial | Multiple |
| **96374** | 90774 | intravenous push, single or **initial** substance/drug | 1 |
| +96375 | 90775 | each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure) | Multiple |
| +96376 | 90776 | each additional sequential intravenous push of a new substance/drug provided **in a facility** (List separately in addition to code for primary procedure) **Cannot be billed on the CMS-1500.** | Bundled into other payment |
| 96379 | 90779 | Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion | Multiple |

| Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration | | | |
|---|---|---|---|
| 2009 Code | 2008 Code | Definition | Units |
| No change | 96401 | Chemo administration, subq or IM; non-hormonal anti-neoplastic | Multiple |
| No change | 96402 | hormonal anti-neoplastic | Multiple |
| No change | 96405 | Chemo administration; intralesional, up to & including 7 lesions | Multiple |
| No change | 96406 | intralesional, more than 7 lesions | Multiple |
| No change | **96409** | IV, push technique, single or **initial** substance/drug | 1 |
| No change | +96411 | each additional substance/drug | Multiple |
| No change | **96413** | Chemo administration, IV infusion technique; up to 1 hour, single or **initial** substance/drug | 1 |
| No change | +96415 | each additional hour | Multiple |
| No change | 96416 | initiation of prolonged chemo infusion (more than 8 hrs), requiring use of a portable or implantable pump | 1 |

| | | | |
|---|---|---|---|
| No change | +96417 | each additional sequential infusion (different substance/ drug), up to 1 hour (List separately in addition to code for primary procedure) | Multiple |
| No change | 96420 | Chemo administration, intra-arterial; push technique | Multiple |
| No change | 96422 | infusion technique, up to 1 hour | 1 |
| No change | +96423 | infusion technique, each additional hour (List separately in addition to code for primary procedure) | Multiple |
| No change | 96425 | infusion technique, initiation of prolonged infusion (more than 8 hrs), requiring the use of a portable or implantable pump | 1 |
| No change | 96440 | Chemo administration into pleural cavity, requiring & including thoracentesis | Multiple |
| No change | 96445 | Chemo administration into peritoneal cavity, requiring & including peritoneocentesis | Multiple |
| No change | 96450 | Chemo administration, into CNS (e.g. intrathecal), requiring & including spinal puncture | Multiple |
| No change | 96521 | Refilling & maint. of portable pump | 1 |
| No change | 96522 | Refilling & maint. of implantable pump or reservoir for drug delivery, systemic (e.g. IV, intra-arterial) | 1 |
| No change | 96523 | Irrigation of implanted venous access device for drug delivery systems | 1 |
| No change | 96542 | Chemo injection, subarachnoid or intraventricular via subq reservoir, single or multiple agents | Multiple |
| No change | 96549 | Unlisted chemotherapy procedure | Multiple |
| No change | C8957 | IV infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hrs), requiring the use of portable or implantable pump | 1 |

## Chemotherapy/Therapeutic Infusion Administration - Professional

***ctive for services on or after January 1, 2009***

The American Medical Association (AMA) has re-categorized and re-numbered the CPT® codes that identify hydration, diagnostic and therapeutic injections and infusions to align more closely with codes used for chemotherapy administration for calendar year 2009. These new codes for hydration, diagnostic and therapeutic injections and infusions continue to follow the same guidelines as the previous series of codes. CPT® 2009 provides a great deal of parenthetical information that is important to use when billing these services. The following guidelines apply to use of these codes for professional claims.

1. CPT® specifically notes that new code 96376 is for use by the facility only. This code should not be billed by the physician on the CMS-1500.
2. This series of codes includes an "initial" service code. This is the code that best describes the key reason for the patient encounter. It does not reflect the order that the infusions or injections occur.
   a. If a patient is admitted for the primary purpose of chemotherapy, but receives other infusions prior to the chemotherapy, the chemotherapy "initial" code is the only "initial" code used.
   b. There is only one "initial" drug administration code per encounter. The only exceptions to this are if the protocol requires that two (2) separate IV sites must be utilized, or if the patient comes back for a second encounter on the same date of service. These services would be identified with modifier 59. Medical documentation must justify the use of the modifier.
3. The chemotherapy administration codes (96401 - 96549) are for use with the parenteral administration of non-radionuclide anti-neoplastic drugs and anti-neoplastic agents provided for treatment of noncancer diagnoses. They may also be used for substances such as certain monoclonal antibody agents and other biologic response modifiers. These highly complex substances require additional physician and staff monitoring due to the higher incidence and severity of adverse reactions. Beginning January 1, 2009, only certain pharmaceuticals will be allowed to be used with the chemotherapy administration codes. These include J9001-J9999, J1745 or J0894. Chemotherapy administration codes are not used for intravenous immunoglobulin (IVIG). IVIG is billed under herapeutic/diagnosis infusions.

4. In order to bill "each additional hour", a minimum of 31 additional minutes of services must be provided. Time units are calculated based on how long the fluid is actually infusing into the patient. Time ends when the fluids have infused. Documentation within the medical record should substantiate start and stop times for the services. An infusion of 15 minutes or less should be reported using a "push" code.
5. An intravenous or intra-arterial push is defined as:
   - An injection administered by a health care professional who is continuously present to administer the injection and observe the patient OR
   - An infusion of 15 minutes or less. An infusion of 15 minutes or less should be reported using a "push" code.
6. An IV line that only provides hydration, and is considered an integral part of chemotherapy or drug administration, is not separately reportable. This service is included in chemotherapy or other therapeutic administration codes.
7. Hydration codes are intended to report IV infusion of pre-packaged fluid and/or electrolytes, but should not be used to report infusion of drugs or other substances.
8. Code 96367 (additional sequential infusion, up to 1 hour) is used to report the infusion of a second or subsequent drug after the initial drug. This must be a sequential infusion - not a concurrent infusion. 96367 is reported once per drug.
9. Code 96368 identifies a concurrent infusion. It is an add-on code and must be listed separately in addition to the code for the primary procedure.
   a. A concurrent infusion is when multiple infusions are provided simultaneously through the same intravenous line.
   b. Multiple substances mixed in one bag are considered to be one infusion.
   c. The concurrent infusion code can only be billed once per day.
   d. This code should not be used for chemotherapy infusions - it is used to report therapeutic/diagnostic infusions only.
10. Code 96523 identifies a port flush and should be used when a patient comes only to have their port flushed with saline. This code should not be reported if any other service related to the port (i.e. lab draw or other infusion) is performed that day and will be reimbursed when it is the only service provided.
11. Services such as the use of local anesthesia, IV start, access to indwelling IV (a subcutaneous catheter or port), a flush at the conclusion of an infusion, standard tubing, syringes and supplies are included in the payment for the drug administration service. These services should not be billed separately.
12. E&M code 99211 should not be separately reported when drug administration services are provided. These services are incorporated into the RVUs for the administration codes.

The following CPT® codes are available for services. Codes in bold print identify initial services. ("+" indicates add-on code)

| Hydration Administration Codes | | |
|---|---|---|
| **2009 Code** | **2008 Code** | **Definition** |
| 96360 | 90760 | Intravenous infusion, hydration; **initial**, 31 minutes to 1 hour |
| +96361 | 90761 | each additional hour (List separately in addition to code for primary procedure) |
| **Therapeutic, Prophylactic, and Diagnostic Injections and Infusions** | | |
| **2009 Code** | **2008 Code** | **Definition** |
| **96365** | 90765 | Intravenous infusion, for therapy, prophylaxis, or diagnosis; **initial**, up to 1 hour |
| +96366 | 90766 | each additional hour (List separately in addition to code for primary procedure) |
| +96367 | 90767 | additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure) |
| +96368 | 90768 | concurrent infusion (List separately in addition to code for primary procedure) |
| **96369** | 90769 | Subcutaneous infusion for therapy or prophylaxis; **initial**, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s) |
| +96370 | 90770 | each additional hour (List separately in additon to code for primary procedure) |
| +96371 | 90771 | additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure) |
| 96372 | 90772 | Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular |
| 96373 | 90773 | intra-arterial |

| | | |
|---|---|---|
| 96374 | 90774 | intravenous push, single or initial substance/drug |
| +96375 | 90775 | each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure) |
| +96376 | 90776 | each additional sequential intravenous push of a new substance/drug provided in a facility (List separately in addition to code for primary procedure) **Cannot be billed on the CMS-1500.** |
| 96379 | 90779 | Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion |

**Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration**

| 2009 Code | 2008 Code | Definition |
|---|---|---|
| No change | 96401 | Chemo administration, subq or IM; non-hormonal anti-neoplastic |
| No change | 96402 | hormonal anti-neoplastic |
| No change | 96405 | Chemo administration; intralesional, up to & including 7 lesions |
| change | 96406 | intralesional, more than 7 lesions |
| No change | 96409 | IV, push technique, single or initial substance/drug |
| No change | +96411 | each additional substance/drug |
| No change | 96413 | Chemo administration, IV infusion technique; up to 1 hour, single or initial substance/drug |
| No change | +96415 | each additional hour |
| No change | 96416 | initiation of prolonged chemo infusion (more than 8 hrs), requiring use of a portable or implantable pump |
| No change | +96417 | each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure) |
| No change | 96420 | Chemo administration, intra-arterial; push technique |
| No change | 96422 | infusion technique, up to 1 hour |
| No change | +96423 | infusion technique, each additional hour (List separately in addition to code for primary procedure) |
| No change | 96425 | infusion technique, initiation of prolonged infusion (more than 8 hrs), requiring the use of a portable or implantable pump |
| No change | 96440 | Chemo administration into pleural cavity, requiring & including thoracentesis |
| No change | 96445 | Chemo administration into peritoneal cavity, requiring & including peritoneocentesis |
| No change | 96450 | Chemo administration, into CNS (e.g. intrathecal), requiring & including spinal puncture |
| No change | 96521 | Refilling & maint. of portable pump |
| No change | 96522 | Refilling & maint. of implantable pump or reservoir for drug delivery, systemic (e.g. IV, intra-arterial) |
| No change | 96523 | Irrigation of implanted venous access device for drug delivery systems |
| No change | 96542 | Chemo injection, subarachnoid or intraventricular via subq reservoir, single or multiple agents |
| No change | 96549 | Unlisted chemotherapy procedure |

## Diagnosis Coding

Providers must always use the most appropriate ICD-9-CM diagnosis code based on the date of service. ICD-9-CM makes changes to diagnosis codes that become effective on dates of service on or after October 1 of the current year through September 30 of the following year. These changes consist of new, revised and deleted codes. Many of the changes involve use of an additional digit to an already established code. Any diagnosis code without the correct number of digits is considered incomplete and therefore invalid, in the same way that a deleted diagnosis code is invalid.

ICD-9-CM diagnosis codes may be three, four or five digits in length. The ICD-9-CM manual clearly identifies codes that require a fourth or fifth digit. It is necessary that the diagnosis be coded out to the correct level of specificity required. Placing two zeroes at the end of a three digit code will not always create a valid code.

A current ICD-9-CM listing should be used if there is a question as to the number of digits required and the codes available. For example:

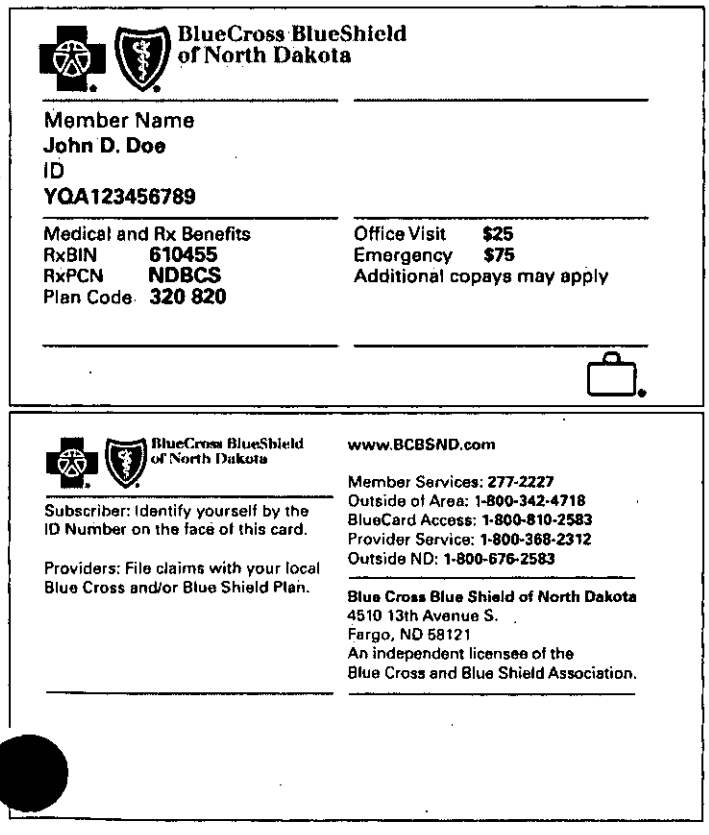
- Diagnosis code 799 (Other ill-defined and unknown causes of morbidity and mortality) **Not valid** as a 4th digit is required.
- Diagnosis code 799.0 (Asphyxia and hypoxemia) **Not valid** as a 5th digit is required. Using two zeroes does not create a valid code since there is no 799.00.
- Diagnosis code 799.1 (Respiratory arrest) **Valid** diagnosis code.

# ID Cards

## New Design for Member ID Cards

Blue Cross Blue Shield of North Dakota identification cards are getting a fresh, new look as a result of a Blue Cross and Blue Shield Association mandate for all BCBS Plans nationwide. The format makes it easier to locate the member's name, ID number and Blue Plan logo on the front of the card, and pertinent contact information on the back.

New cards will be distributed upon the member's contract renewal date. The first phase of the ID card implementation begins in January 2009 and will continue until all new cards are distributed, or no later than January 1, 2011. Both old and new versions of the ID card are valid until January 1, 2011.




# Employer Group Benefits

## Doosan Infracore International

Effective January 1, 2009, Blue Cross Blue Shield of North Dakota will administer Doosan's salaried employee PPO health plan and dental plans. The benefit plan number alpha prefix is DDU. The network is Preferred Blue in North Dakota and BlueCard PPO out-of-state. Prescription drug benefits are administered through CVS/Caremark. For questions regarding benefits available under this group, call Provider Service at 800-368-2312 or 701-282-1090.

| | In-Network | Out-of-Network |
|---|---|---|
| **Single** | | |
| Deductible | $ 200 | $ 500 |
| Coinsurance | $1,300 | $2,500 |
| Out of Pocket Maximum | $1,500 | $3,000 |
| | | |
| **Two-Party** | | |
| Deductible | $ 400 | $1,000 |
| Coinsurance | $2,600 | $5,000 |
| Out of Pocket Maximum | $3,000 | $6,000 |
| | | |
| **Family** | | |
| Deductible | $ 400 | $1,000 |
| Coinsurance | $2,600 | $5,000 |
| Out of Pocket Maximum | $3,000 | $6,000 |

# THORConnect.org

## Winner Announced!

In the November issue of *HealthCare News* and *Provider News*, you were given the opportunity to review the revised provider website, www.THORConnect.org, offer feedback and win a prize. We would like to thank all who contributed ideas and suggestions!

The winner is Marcy Grewe from Innovis Hospital, Fargo. She received a BCBSND windshirt.

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# THOR

## Update Your User Profile

The Forgot Password feature is now available on THOR. To use this new feature, you must answer five security questions found on the User Profile link. If you ever need to request a temporary password, you will be asked to provide answers to the security questions stored in your user profile account. Upon successfully answering these questions, a temporary password will be emailed to you.

If you have any questions or need assistance with your profile, contact Application Support Services at 800-544-8467 or e-mail thor.support@thor.org.

# Glad You Asked!

## Microsurgical Epididymal Sperm Aspiration

**Question:** Is it appropriate to use CPT® code 55899 (unlisted procedure, male genital system) for microsurgical epididymal sperm aspiration (MESA)?

**Response:** No, it is not appropriate to use an unlisted procedure code if there is a more specific code for the procedure. The correct code for this procedure is HCPCS code S4028 [(microsurgical epididymal sperm aspiration (MESA)]. This procedure is one of the techniques used for sperm harvesting.

THOR (The Healthcare Online Resource) is a user-friendly tool that can virtually eliminate the need for lengthy telephone inquiries - not to mention lots of paper documents - by electronically connecting providers, payers and other professionals.

THOR Applications being offered: Bulletin Board, Claim Inquiry, Claim Adjustment, Claim Correction, Contraceptive Medication Request, Membership, Injectables/Other Pharmacy Fee Schedule, Locus (Adult and/or Child), Non-Formulary Medication Request, North Dakota Immunization Information System, Physician Payment Schedule, Preauthorization and Referral, Provider Data Exchange, Reference Lab List and Provider Directory.

If interested: Register online at www.THORConnect.org
Call Application Support Services at 1-800-544-THOR (8467) for a demonstration