provider hcrnews

New Rules, New Challenges, **New Opportunities**

Provider HCR (health care reform) News is a monthly special edition publication for network providers from the Network Administration Division of Blue Cross and Blue Shield of Louisiana.

This Issue: Risk Adjustment November 2013

RISK ADJUSTMENT and PREDICTIVE MODELING

risk adjustment [risk • uh-juhst-muh nt] *noun* - the process of using diagnosis codes put on claims to determine the disease state or illness burden of a patient

Risk Adjustment is a big part of the Affordable Care Act's (ACA's) financial backbone and very important to preserving the private insurance market. Risk adjustment is the stabilizing process being put into place by the ACA for determining the disease burden of members in each health plan. This process applies to non-grandfathered individual and small group business in and out of the Marketplace.

As you may already know, with the new healthcare reform law, underwriting and pre-existing conditions will soon be a thing of the past beginning January 1, 2014. The ACA guarantees access to healthcare coverage for all. Indeed, individuals must have coverage or pay a penalty. This means that there is the potential of a higher mix of sick versus healthy people entering the individual market.

The ACA has also called for a premium setting process with limited rating factors that healthcare carriers, including Blue Cross and Blue Shield of Louisiana, must use for determining premiums for non-grandfathered individual and small group policies that are effective on and after January 1, 2014. The ACA's factors include:

- geographic location
- age
- tobacco use

Rates cannot vary by health status or gender.

Blue Cross is using the Commercial Risk Adjustment (CRA) model that the ACA has adopted to predict healthcare costs based on enrollees in risk-adjustment-covered plans. The model incorporates organized diagnosis codes also known as HCCs (hierarchical condition categories) that correlate or link to corresponding diagnosis categories.

Based on a comparison of the risk levels of each health plan's enrollment, Blue Cross may be required to pay money into or receive money from the aggregate pool of all health plans. The U.S. Department of Health & Human Services (HHS), through the CRA program, redistributes money from healthcare insurers with healthier patient populations to those with less healthy populations. Therefore, it is important that the data we receive from providers accurately and completely reflects the risk of the members enrolled in Blue Cross and Blue Shield of Louisiana's benefit plans.

In preparation for 2014, it is critical that Blue Cross receive complete and accurately coded claims to properly indicate our members' health status.

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Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

Calculating Risk

Why CALCULATING RISK is IMPORTANT

In Louisiana, the federal government is responsible for operating the risk-adjustment model *[also referred to as the Commercial Risk Adjustment (CRA) program]*. This component of the new healthcare law is designed to be a tool for healthcare insurer stability to improve the ACA's new rules of coverage, preserving consumer choice and improving quality of care for patients through care-management programs.

In 2014, every healthcare insurer (not just Blue Cross) is required to participate in the CRA program for non-grandfathered plans and may be required to share their premium revenues with the other healthcare insurers in the Marketplace based on the relative complexity of their members' health. Plans with healthy patient populations will make payments, while plans with a higher member illness burden will receive funds. The goal of the risk adjustment model is to offset adverse selection of members in the Marketplace.

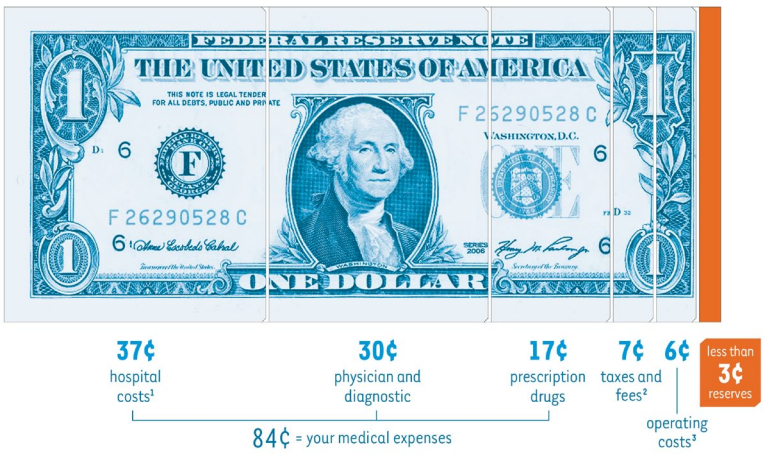
Data reported to the risk adjustment model is based on a calendar year of claims data. This is why it is so CRITICAL that the claims we receive from our providers reflect the TOTAL RISK profile of each patient.

How BLUE CROSS uses each PREMIUM DOLLAR

It's important to understand that the vast majority of premium dollars that consumers pay go toward their own medical costs. This will not change under the ACA. In fact, the ACA introduced new Medical Loss Ratio (MLR) requirements, which went into effect two years ago. The ACAs' requirements are as follows:

- Healthcare insurers must use 80 to 85 percent of premiums on medical care, depending on whether the customer is an individual, small group, etc.
- Healthcare insurers must issue premium rebates to customers if that minimum 80 to 85 percent standard is not met.

Blue Cross and Blue Shield of Louisiana has consistently met these standards for years, long before it was a requirement, and we expect this to continue. The 3¢ savings on every dollar is put in a reserve fund for paying claims including, in times of unforeseeable events such as Hurricane Katrina. Putting the savings into a reserve fund is not typical of a healthcare insurer; however, because we are owned by our policyholders we're able to put it away for a "rainy day" for our members instead of Wall Street.



[1] Physician services include doctor visits and services, imaging (such as x-rays or MRIs) and outpatient services not performed in a hospital.

[2] Taxes include state and federal taxes: fees consist of regulatory assessments.

[3] Operating costs consist of salaries, utilities, etc.

COMMERCIAL RISK ADJUSTMENT EXAMPLE and STATISTICS

Shown below is an example of a 61 year old male and the impact of a missing risk-adjusted diagnosis code and an unspecified code.

ICD-9 Codes	Risk Score
Diagnostic Component	
251.4 - Abnormality of secretion of glucagon	3.281
427.31 - Atrial fibrillation	3.112
453.74 - Chronic venous embolism and thrombosis of axillary veins	4.549
Demographic Component	
61 year old male	0.704
Relative Risk Score	**11.646**

ICD-9 Codes	Risk Score
Diagnostic Component	
251.4 - Abnormality of secretion of glucagon	3.281
~~427.31 - Atrial fibrillation~~	~~3.112~~
453.73 - Chronic venous embolism and thrombosis of upper extremity; **unspecified**	0.000
Demographic Component	
61 year old male	0.704
Relative Risk Score	**3.985**

Missing one chronic condition and coding one unspecified diagnosis code reduces the relative risk score by 66 percent.

Diagnosis Code Capture Statistics *(specific to Blue Cross)*

- On average we receive fewer than two diagnosis codes on a claim (average is 1.96)
- Less than 3 percent of claims contain 5 or more diagnosis codes
- Less than 67 percent of members with a chronic condition in the prior year have been coded in the current year
- 25 percent of diagnosis codes are unspecified or not elsewhere classified

What is the PROVIDER'S ROLE toward RISK ADJUSTMENT?

Risk adjustment relies on providers to perform accurate medical record documentation and coding practices in order to capture the complete risk profile of each individual patient. This practice allows Blue Cross opportunities to improve members' care.

Accurate risk-capture improves high-risk patient identification and our ability to reach out/engage patients in care management programs and care prevention initiatives. It also helps in the endeavor to identify practice patterns and reduce variation when clinically appropriate.

Accurate medical records and diagnosis codes captured on claims help reduce the administrative burden of medical record requests and adjusting claims for both the provider's office and healthcare insurers. This also allows Blue Cross opportunities to improve our risk- adjustment predictions.

IMPLICATIONS of CODING ERRORS

Did you know that the estimated cost for a provider to resubmit an adjusted or corrected claim ranges, on average, from $15 to $25 per claim? The journey of just one claim that must be resubmitted includes the initial claim being received. Processing claims includes edits and/or retrospective reviews checking for potential errors. Upon discovery of an error, the claim is returned/denied for a corrected claim. The provider must then resubmit a corrected claim to begin the process again. Just 100 claim resubmissions could result in a loss of $1,500. In addition to wasted provider resources, other system stakeholders are forced to use already strapped resources to resolve claim issues. Accurate claims equate to accurate risk- adjustment assessments and more.

Medical Records

Medical coding of patient encounters is only as good as the underlying medical record documentation.

BEST PRACTICES in MEDICAL RECORD DOCUMENTATION

- Documentation needs to be sufficient to support and substantiate coding for claims or encounter data
- Diagnoses cannot be inferred from physician orders, nursing notes or lab or diagnostic test results; diagnoses need to be in the medical record
- Chronic conditions need to be reported every calendar year (e.g., leg amputation status must be reported each year)
- Each diagnosis needs to conform to the ICD-9 coding guidelines until transition to ICD-10
- Medical records need to be legible, signed, credentialed and dated by the physician
- Patient's name and date of service need to appear on all pages of the record
- Treatment and reason for level of care need to be clearly documented; chronic conditions that potentially affect the treatment choices considered should be documented
- Failure to properly code claims could lead to an audit process and may affect claims payments

RISK ADJUSTMENT CHANGES that AFFECT our PROVIDERS

As Blue Cross adapts to the risk-adjustment process, it is necessary for us to implement policy changes to govern how our network providers report claims. ACCURATELY and FULLY coded claims have long-term benefits for our members and providers as well as Blue Cross. Accurate medical records and diagnosis codes captured on claims the "first time" helps you reduce the administrative burden of medical record requests from Blue Cross necessary to adjust claims to reflect the actual risk profile of members. For providers involved in our value-based payments, it also ensures more accurate payments through reflection of members' risk. Some of the changes we are implementing include:

- Effective January 1, 2014, we will no longer accept interim billing on facility claims (services filed on a UB-04 claim form)
- Blue Cross will require diagnosis code specificity on all claims (professional and facility)
- Providers may begin filing professional claims on the newly revised CMS-1500 claim form on January 6, 2014. Then, effective April 1, 2014, providers may no longer use the old CMS-1500 claim form.
- Providers MUST use ICD-10 diagnosis codes for dates of service on and after October 1, 2014.

Full details on these changes are outlined in the following pages of this newsletter.

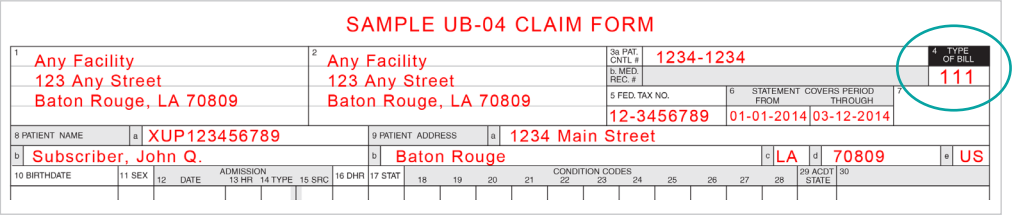
Accurately Coded Claims = Accurate Data for Determining Risk

CHANGES that AFFECT FACILITY CLAIMS

INTERIM BILLING NOT ACCEPTED - Interim billing are bills sent at regular intervals for patients who have lengthy stays in a hospital or facility or long-term outpatient facility services. Inpatient and outpatient billing of services cannot be submitted as "interim" bills. Today, Blue Cross does not accept interim billings for inpatient facility services billed on a UB-04 claim form. However, we have not returned claims received with interim bill types. Effective January 1, 2014, Blue Cross will no longer accept interim bills for both inpatient and outpatient facility services billed on a UB-04 claim form. The only acceptable bill types are xx1 and xx7. We will **reject** facility claims received with the bill type ending with one of the following numbers:

- xx2
- xx3
- xx4
- xx5
- xx6
- xx9

Blue Cross' electronic claims filing system is no longer limited to 22 lines per electronic UB-04 claim.


SAMPLE UB-04 CLAIM FORM

1 Any Facility
123 Any Street
Baton Rouge, LA 70809

2 Any Facility
123 Any Street
Baton Rouge, LA 70809

3a PAT. CNTL # 1234-1234
b. MED. REC. #
4 TYPE OF BILL 111
5 FED. TAX NO. 12-3456789
6 STATEMENT COVERS PERIOD FROM 01-01-2014 THROUGH 03-12-2014
7

8 PATIENT NAME a XUP123456789
b Subscriber, John Q.
9 PATIENT ADDRESS a 1234 Main Street
b Baton Rouge c LA d 70809 e US
10 BIRTHDATE 11 SEX 12 DATE ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 29 ACDT STATE 30

Bill types ending in "1" or "7" are acceptable.

CHANGES that AFFECT ALL PROVIDERS

Diagnosis Code Specificity Required - It is important to file ALL applicable diagnosis codes on a claim. It is equally important that providers code claims to the highest degree of specificity.

Blue Cross discourages providers from filing "not otherwise specified" (NOS) diagnosis codes. Claims with NOS codes may pend for medical record review and more appropriate coding. Use the following specificity rules for filing claims:

- **Always** report the most specific diagnosis codes. Example: Only use 3-digit ICD-9 codes when 4-digit codes are not available and 4-digit codes when 5-digit codes are not available in a particular category. Though the code sets are different for ICD-10 codes, the same principles apply. **Always report the most specific codes**.
- **Always** include all related diagnoses, including chronic conditions you are treating the member for.
- **Always** include an additional code when required to provide a more complete picture. For example, in etiology/ manifestation coding, the underlying condition is coded first followed by the manifestation.
- Medical records **must support ALL** diagnosis codes on claims.
- Filing claims with NOS (not otherwise specified) and NEC (not elsewhere classified) diagnosis codes is not preferred. Filing claims with NOS and NEC codes delays claim processing and may result in Blue Cross requesting medical records. It may also result in delayed payment and possible payment reductions.

NOS
Not Otherwise Specified
The medical record lacks information to be able to assign a more specified diagnosis code

NEC
Not Elsewhere Classified
The ICD-9-CM code does not have a code that describes the condition

New Claim Form

Did you know?

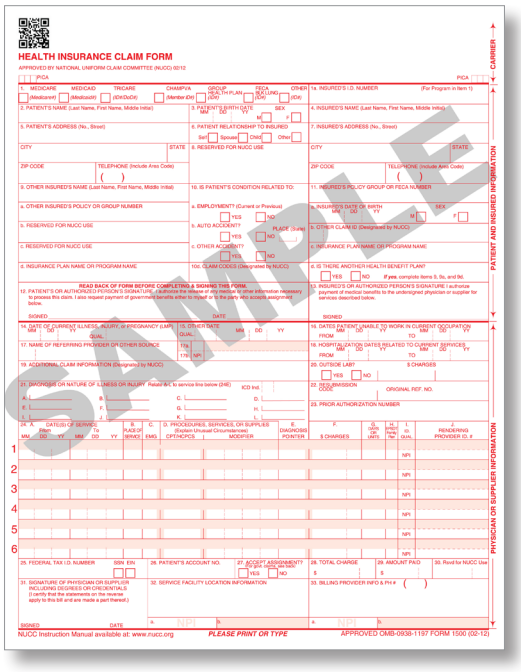
Today, you can report up to 12 diagnosis codes per electronic professional claim form. Of those 12 codes, you can report up to four codes per claim line.

You can report up to 26 diagnosis codes on the electronic facility claim form.

- Today, preliminary claims data analysis shows that many primary care physicians and specialists submit only one diagnosis code per claim
- On the revised CMS-1500 claim form, providers may also report up to 12 diagnosis codes
- Providers who submit only one diagnosis on all claims will be monitored and targeted for audit of medical records.

The NEW CMS-1500 CLAIM FORM

In preparation for healthcare reform and also the use of ICD-10 diagnosis codes, The Centers for Medicare & Medicaid Services (CMS) has released a revised CMS-1500 claim form. The revision date for the new claim form is "version 02/12," replacing "version 08/05."



Beginning January 6, 2014, providers may begin using this form to file claims directly to Medicare and/or Blue Cross. Though providers should still file claims using ICD-9 diagnosis codes, on April 1, 2014, both Medicare and Blue Cross will no longer accept professional claims filed on the old CMS-1500 claim form.

The primary change to the form accommodates identification of ICD-9 and ICD-10. The form has been expanded to allow 12 possible ICD-9 or ICD-10 diagnosis codes instead of the current four diagnosis codes. The new form includes an "ICD Indicator" field to report whether filing with ICD-9 or ICD-10 codes.

ICD-9-codes must be used for dates of service prior to October 1, 2014, and ICD-10 codes must be used for dates of service on and after October 1, 2014.

A copy of the revised CMS-1500 form is available online at www.nucc.org/%5Cimages%5Cstories%5CPDF%5C1500_claim_form_2012_02.pdf?utm_medium=email&utm_source=govdelivery.

FILING the CORRECT DIAGNOSIS CODES on CLAIMS

By now, you should be preparing for the conversion to the 10th version of the International Classification of Diseases code set (ICD-10). All HIPAA-covered entities are required to use ICD-10 on all transactions, including claims, authorization and referral requests and verification of eligibility for services on and after October 1, 2014.

Blue Cross is taking the necessary steps to ensure that all systems and processes will accommodate ICD-10 by the federal compliance date. All transactions, electronic or paper-based, for services on and after the compliance date of October 1, 2014, must contain ICD-10 codes or they will be rejected. In order to accomplish a successful transition to ICD-10, providers, vendors and payers must work closely together. Some of the major changes for ICD-10 include:

- The introduction of laterality, causation and location of injury (e.g., left versus right ligament of the ankle)
- The standardization and extension of the code structure (three to seven characters and each character has a standard meaning)
- The introduction of co-morbidity within a single code (e.g. diabetes with heart disease)

The Transition to ICD-10 codes will allow for necessary details on patient medical conditions and on procedures performed during a patient's hospitalization. Plus, ICD-9 codes have outdated and obsolete terminology and are also inconsistent with current medical practices.

Do not assume billing vendors will be compliant. You are ultimately responsible for your claims. We recommend that you contact your clearinghouse, billing services and vendors to determine readiness. Blue Cross will NOT accept ICD-9 codes for dates of service on or after October 1, 2014.

What can I do to *get involved?*

Join Blue Cross and Blue Shield of Louisiana and the Louisiana Healthcare Education Coalition (LHEC), a civic organization committed to providing unbiased healthcare and wellness information to the people of our state. LHEC is looking for like-minded partners to join in addressing key issues, such as steering through the new healthcare system, the major drivers of healthcare costs, the critical importance of personal wellness and the need for system transformation to increase quality while reducing cost.

To learn more, contact:

lhec@bcbsla.com or **visit www.lhec.net**

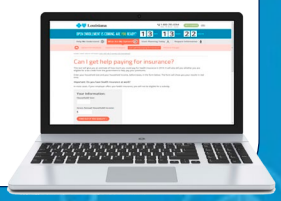
LHEC
Louisiana Healthcare Education Coalition

WHAT WILL YOU PAY FOR **HEALTH INSURANCE IN 2014?**

CAN YOU GET HELP PAYING **YOUR PREMIUMS?**

WHO QUALIFIES FOR **TAX CREDITS?**

We have created an easy online tool to estimate what you'll pay for health insurance next year. Find out if you qualify for a tax credit from the federal government to help pay your premiums. If your employer offers health insurance, you probably won't qualify. Go to www.bcbsla.com/whatyoupay and find out in seconds what your estimated cost will be. While you're there, check out your options, learn about healthcare reform and start planning today!



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Healthcare Reform: *New Rules, New Challenges,* New Opportunities

Find more online about healthcare reform at:

www.BCBSLA.com/reform

HCR News

HCR News is newsletter on Healthcare Reform changes for Blue Cross and Blue Shield of Louisiana network providers. We encourage you to share this newsletter with your staff.

The content in this newsletter is for informational purposes only. Diagnosis, treatment recommendations and the provision of medical care services for Blue Cross members are the responsibilities of healthcare professionals and facility providers.

If you would like to receive this newsletter by email, please contact us at provider.communications@bcbsla.com.

PROVIDER RESOURCES

Reform Web	www.BCBSLA.com/reform www.LHEC.net
Provider Web	www.BCBSLA.com >I'm a Provider
iLinkBLUE & EFT	iLinkBLUE.ProviderInfo@bcbsla.com 1.800.216.BLUE (2583)
Provider Relations	Provider.Relations@bcbsla.com 1.800.716.2299, option 4
Network Development	Network.Administration@bcbsla.com 1.800.716.2299, option 1
Provider Services	1.800.922.8866