



October 25, 2011

Bob Lisson, PhD  
Deputy Commissioner  
Consumer Services Division  
North Carolina Department of Insurance

Sent by email to [bob.lisson@ncdoi.gov](mailto:bob.lisson@ncdoi.gov)

Dear Dr. Lisson:

This complaint details the shared concerns of the North Carolina Medical Society, the North Carolina Radiological Society, and the North Carolina Hospital Association over a proposed Corporate Medical Policy (CMP) issued by Blue Cross and Blue Shield of North Carolina (BCBSNC). If implemented, the CMP will unilaterally reduce the fees owed to BCBSNC participating providers who perform certain imaging procedures.

As outlined below, state insurance laws prohibit BCBSNC from implementing the CMP in the manner proposed. Recent conversations between the parties have not resolved this dispute, so we now request that the North Carolina Department of Insurance (NCDOI) take appropriate action to ensure that BCBSNC complies with the relevant statutes.

#### Background

Many radiology, orthopaedic, OB/GYN, and other physician practices and health care facilities in North Carolina hold participation agreements with BCBSNC. As participants in the BCBSNC provider network, they commonly provide covered imaging services to BCBSNC members. In June 2011, BCBSNC provided notice of its intention to implement a new CMP entitled "Radiology Services Reimbursement Guidelines" (Attachment 1). BCBSNC scheduled the policy to take effect October 1, 2011. The policy stated, "[w]hen multiple radiological procedures are performed during the same outpatient patient session, the technical component of the second and subsequent imaging procedures will be subject to a fee reduction." The CMP identified ultrasound, MRI/MRA, and CT/CTA as the imaging procedures subject to the reduction.

BCBSNC withdrew the CMP on September 30 after hearing objections from the provider community. BCBSNC revised and reissued the CMP that same day, scheduling it to take effect December 1, 2011. The revised version (Attachment 2) states:

**When multiple radiological procedures are performed during the same outpatient patient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 50%.**

Despite the substitution of the word "allowance" for "fee" and some other minor changes, BCBSNC's intent remains the same: to cut the technical component of the allowable amount by 50% on second and

subsequent imaging procedures in select outpatient cases. The effect will still be a reduction of the fee paid to providers of these services.

### Analysis

If the CMP takes effect, BCBSNC would violate state law in the following ways.

**1. The CMP is a health plan policy that conflicts with provider contract fee schedules previously agreed upon between medical practices/facilities and BCBSNC.**

BCBSNC cannot implement the CMP because it creates a conflict with provider contract fee schedules. State law provides that “[t]he policies and procedures of a health benefit plan or insurer shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict, the contract language shall prevail.” N.C.G.S. § 58-50-285(b).

Contract fee schedules list specific procedures and the corresponding allowable amounts that BCBSNC will pay to the provider when those services are rendered to BCBSNC members. However, the CMP explicitly states that in outpatient settings where multiple imaging procedures are performed, BCBSNC will reduce the allowance for the technical component by 50% on those multiple procedures. Thus the CMP unilaterally reduces the amount previously negotiated between BCBSNC and the provider in the contract fee schedule for certain CT, MRI, and ultrasound imaging procedures.

The CMP therefore creates a direct conflict with provider contract fee schedules. Under state law, the terms of the contract and fee schedule should prevail.

**2. Because the CMP would modify fees owed to providers of select imaging procedures, BCBSNC must follow the formal statutory process for amending those provider contracts.**

While BCBSNC hopes to implement the CMP as an across-the-board policy change, the CMP actually meets the definition of a contract amendment and triggers a series of additional legal requirements. Under N.C.G.S. § 58-50-270, an amendment is “any change to the terms of the contract, including terms incorporated by reference, that modifies fee schedules.”

First, the proposed Radiology Services CMP is a term incorporated by reference. BCBSNC’s standard Network Participation Agreement for professional services (Attachment 3) specifically states that its Provider Manual containing current policies and procedures is incorporated by reference into the contract.<sup>1</sup> Section 2.3 of the contract also requires the provider to “participate in and comply with all [BCBSNC] Policies and Procedures” under threat of sanctions and termination from the network. BCBSNC policies are clearly terms incorporated into the contract by reference that participating providers are required to follow.

Second, the CMP will change the terms of in-force provider contracts by modifying fees. Currently these imaging procedures are subject to reimbursement by BCBSNC at the allowed amount (i.e., the fee schedule rate), regardless of the patient or the session. The CMP advises that BCBSNC will reimburse an initial CT, MRI, or ultrasound at the allowed rate, but “the allowance for the technical component of the second and subsequent

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<sup>1</sup> See Section 3.2.5., stating “We agree to provide a provider manual, incorporated herein by reference, containing current information concerning benefit exclusions and Policies and Procedures.”

procedure is 50%.” The Corporate Medical Policy unilaterally modifies the fee schedule that was mutually agreed upon and captured in the participation agreement.

The Department has addressed this issue in filings by other insurers, instructing that policies that have the “effect” of changing a fee schedule are in fact fee schedule changes subject to the laws governing those changes.<sup>2</sup> Because the CMP seeks to change the terms of BCBSNC’s contracts with providers in a way that modifies fee schedules, the CMP qualifies as a contract amendment under state law. Accordingly, BCBSNC must follow the formal contract amendment process established under § 58-50-270 *et seq.*, should it desire to implement this CMP.

**3. The state law governing reimbursement policy disclosures does not authorize BCBSNC to implement the CMP in lieu of complying with the fair contracting statutes discussed above.**

BCBSNC has argued that N.C.G.S. § 58-3-227, “Health plans fee schedules,” supports the company’s objective because the CMP meets that statute’s description of a “reimbursement policy.” After reviewing § 58-3-227 and BCBSNC’s argument, we respectfully disagree with that conclusion.

The clearly stated purpose of that statute is “to establish the minimum required provisions for the *disclosure and notification* of an insurer’s schedule of fees, claims submission, and reimbursement policies[.]” § 58-3-227(b) (emphasis added). In other words, this statute deals exclusively with the issues of when and how a health plan must communicate with participating providers about reimbursement policies, fee schedules, and changes thereto. This section does not authorize health plans to implement policies, does not articulate any criteria that policies must satisfy to be legally valid, and does not excuse compliance with the directly relevant requirements found at § 58-50-270 *et seq.* We also understand that NCDOL, in reviewing provider contract filings, has informed at least one health insurer that the fair contracting laws supersede § 58-3-227(b).<sup>3</sup>

We therefore consider § 58-3-227 to be inapplicable to these circumstances and feel that BCBSNC’s reliance on that section is misguided.

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<sup>2</sup> See Itemized Objection 4 in NCDOL’s April 12, 2010 disapproval letter in Wellpath’s filing at NCLF-126520327, which states: “Pursuant to NCGS 58-50-270(1), ‘Amendment’ is any change to the terms of a contract, including terms incorporated by reference, that modifies fee schedules. Because the amendments are excluded from electronic delivery method, please modify section 5.1 of the Addendum and indicate that when changes to the policies and procedures *have the effect of changing the fee schedule*, such notices will be delivered in writing and in compliance with NCGS 58-50-275 and NCGS 58-50-280.” (Emphasis added.) See also Itemized Objection 4 in NCDOL’s April 13, 2010 disapproval letter in YARB-126441749, stating, in relevant part: “any change to the fee schedule...whether direct *or through changes in claims and reimbursement policies* must be delivered with at least 60 days prior written notice and in compliance with NCGS 58-50-275 and NCGS 58-50-280.” (Emphasis added.)

<sup>3</sup> See Itemized Objection 4 in NCDOL’s April 13, 2010 Objection Letter in YARB-126441749, instructing the insurer to remove references to N.C.G.S. § 58-3-227 in its filing.

Request to NCDOI

We respectfully request that the NCDOI review BCBSNC's proposed policy and applicable law, and instruct BCBSNC that it must follow the requirements of § 58-50-270 *et seq* before implementing the Radiology Services CMP.

Thank you very much for your consideration of this important matter. We invite you to contact us if we may be of additional assistance during your review of this issue.

Sincerely,



Conor Brockett  
Associate General Counsel  
North Carolina Medical Society  
PO Box 27167  
Raleigh, NC 27611  
919-833-3836



John Bode  
General Counsel  
North Carolina Radiological Society  
PO Box 6338  
Raleigh, NC 27628  
919-881-0338



Linwood Jones  
General Counsel  
North Carolina Hospital Association  
PO Box 4449  
Cary, NC 27519  
919-677-2400

Copy: Wayne Goodwin, Commissioner, North Carolina Department of Insurance  
Robert Seligson, Executive Vice President & CEO, North Carolina Medical Society  
Andrew Wu, MD, President, North Carolina Radiological Society  
William Pully, President, North Carolina Hospital Association  
Brad Wilson, President & CEO, Blue Cross and Blue Shield of North Carolina

Enclosures