BlueLINK℠

News from Blue Cross and Blue Shield of North Carolina

Spring 2005

Volume No. 10, Issue No. 1

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BlueCross BlueShield of North Carolina

Member Health Partnerships: Health Programs Get New Identity

Several of our successful health management programs now have one umbrella name – Member Health Partnerships℠1. The idea is to engage with our members to help them with their specific health conditions or risk factors.

Moving to the Member Health Partnerships name will allow Blue Cross and Blue Shield of North Carolina (BCBSNC) to present a simple and consolidated picture of the programs available for our members to actively participate in to optimize their health. The new program names are descriptively clear and straightforward:

Old Program Name	New Program Name
Your Asthma Care	Member Health Partnerships – Asthma
Your Baby & You℠1	Member Health Partnerships – Pregnancy
Your Diabetes Care	Member Health Partnerships – Diabetes
Your Healthy Best®1	Member Health Partnerships – Migraine Member Health Partnerships – Fibromyalgia
Your Healthy Best®1 Specialty Services	Member Health Partnerships – Specialty Care
Your Heart Matters	Member Health Partnerships – Heart Disease
Your Renal Care	Member Health Partnerships – Kidney Disease
Healthy Lifestyle Choices℠1	Member Health Partnerships – Healthy Lifestyle Choices
Tobacco Free	Member Health Partnerships – Tobacco Free

Another important change is that, as of January 1, 2005, three of our existing programs – asthma, diabetes, and migraine – changed from "opt-in" to "opt-out" programs. This means that unless members specifically choose not to participate in a particular program they will automatically

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Rx Copayment Reduction for Asthma Program Participants

According to the National Heart, Lung and Blood Institute, inhaled corticosteroids are the preferred treatment for controlling persistent asthma. To encourage members to comply with this important part of their asthma management, Blue Cross and Blue Shield of North Carolina (BCBSNC) is pleased to announce an enhancement to our Member Health Partnerships[SM1] – Asthma program.

Blue Care®, Blue Choice®, and Blue Options[SM] members, who enroll in our asthma program and who have pharmacy benefits through BCBSNC, can receive a reduction in their copayment for Tier 2 inhaled corticosteroids*. They will be able to obtain these specific medications (listed below) at a more affordable Tier 1 copayment level.

Tier 2 Inhaled Corticosteroids

(Available to Member Health Partnerships – Asthma program enrollees at Tier 1 copayment)

- Advair Diskus
- Azmacort Inhalation Aerosol
- Beclovent Inhalation Aerosol
- Flovent Inhalation Aerosol
- Flovent Rotadisk
- Pulmicort Respules
- Pulmicort Turbuhaler
- QVAR Inhalation Aerosol
- Vanceril
- Vanceril Double Strength

In addition to the pharmacy copayment reduction, members who enroll in our asthma program receive:

- Up-to-date information about managing asthma symptoms.
- Personalized support from a specially trained nurse.
- Free peak-flow meters, spacers and other tools to help them work more effectively with their health care team.

Enrolling in the program is easy. BCBSNC members can simply call us at **1-800-218-5295** to get more information about the asthma program, or any other Member Health Partnerships program, or to enroll over the phone.

**The pharmacy copayment reduction is eligible ten business days after enrollment in the program.*

Member Health Partnerships: Health Programs Get New Identity *(continued from page 1)*

receive quarterly condition-specific mailings from BCBSNC. For most programs, members will still be asked to complete a health survey if they want to take full advantage of program features such as customized educational resources, self-management tools and financial incentives. An exception is the Tobacco Free program, which does not require a health survey.

BCBSNC members who would like more information on how to sign up for one of these free, confidential programs can visit us at ***bcbsnc.com***.

New Health Care Debit Card for BlueCard® Members

Beginning this year, you may see some Blue Plan members with a new Blue Cross and/or Blue Shield (BCBS) health care debit card. The health care debit card was launched in January 2005 and has value-added features designed to help you simplify your administration processes and:

- Reduce bad debt
- Reduce paperwork for billing statements
- Minimize bookkeeping and patient-account functions for handling cash and checks
- Avoid unnecessary claim payment delays

Easy To Use

The card allows members to pay for out-of-pocket costs using funds from their health reimbursement arrangement (HRA), health savings account (HSA), or flexible spending account (FSA). Some cards are "stand-alone" debit cards designed to just cover out-of-pocket costs, while others also serve as a member ID card with the member ID number. The card will have the nationally recognized Blue Cross and/or Blue Shield logos, along with the logo from a major debit card such as MasterCard or Visa.

The health care debit cards are easy to use – simply swipe the card like an ordinary debit card. The cards include a magnetic strip so that providers can swipe the card at the point of service to collect necessary copayments or other member out-of-pocket expenses. If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit card.

Combining a health insurance ID card with a source of payment is an added convenience to both BCBS members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

Helpful Tips

- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits by calling **1-800-676-BLUE (2583)** and provide the alpha prefix or use electronic capabilities.
- If the member presents a health care debit card (stand-alone or combined), be sure to verify what the member will owe before processing payment. Select "debit" when running the card through for payment. No PIN is required for use.
- Please do not use the card to process full payment upfront. Applicable coinsurance and deductible amounts may be billed to BCBSNC members only after you have received the Notification of Payment or Explanation of Payment for the services in question.
- Emergency room copayments may be collected at the time service is rendered.
- Any amounts collected erroneously by you from a member for any reason will be refunded to the member within forty-five days of receipt of notification or your discovery of such error.
- If you have any questions about the member's benefits, please contact **1-800-676-BLUE (2583)**.
- For questions about the health care debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

Blue Link Briefs

2005 Provider Workshops

Blue Cross and Blue Shield of North Carolina will host its annual health care physician and hospital workshops in late spring. Workshops will be held in the Eastern, Triad/Triangle and Western regions of our state, with specific city and date information to be included in your invitations. Be sure to plan to attend a workshop in your area, as we will be distributing the revised 2005 *Physician Office Guide* at the meetings. We will also have additional copies of the 2005 *Hospital and Facility Manual* available too.

Assistant Surgeon Criteria

Currently, BCBSNC uses Medicare criteria to determine which procedures are appropriate for assistant surgeons. Effective May 5, 2005, we will switch to ClaimCheck criteria. In changing to ClaimCheck, we will be consistent with our reimbursement related to assistant surgeons. These values have been recommended by the American College of Surgeons.

Guidelines for Assistant Surgeon Benefits

Benefits are allowed when medical necessity and appropriateness of assistant surgeon services are met. An assistant surgeon must be appropriately board certified or otherwise highly qualified as a skilled surgeon and licensed as a physician in the state where the services are being provided.

Physician assistants not employed by a hospital may act as an assistant surgeon when the above criteria are met. RN-LPN-first assistants and physician assistants employed by a hospital are not eligible for reimbursement as surgical assistants. BCBSNC Corporate Medical Policy regarding assistant surgeons may be viewed online at ***bcbsnc.com***.

Are You Putting Your Provider Number On Your Claim Forms?

One of the top reasons that claims are mailed back is for missing or incorrect provider ID numbers. When a claim is submitted without a provider ID number, it delays the processing of the claim because we have to research, sometimes multiple times, and in multiple areas to find the missing number. If the wrong provider ID number is selected, it can result in payment going to the wrong entity, and can also lead to denials when the wrong provider number is selected for the type of service the member received. Please make sure you are putting the correct provider ID number on all claim forms.

E Codes and How to Use Them

The *ICD-9 Professional Coding Manual* contains diagnosis codes that begin with "E." These are supplementary classifications of external causes of injury and poisoning. For example, the range from E810 – E825 describes transport accidents involving a motor vehicle. The manual also indicates that these codes are to be used only for informational purposes and not for the primary diagnosis. BCBSNC will not accept claims with these "E" codes as the primary diagnosis.

Our Policy Regarding Financial Incentives

BCBSNC makes utilization management decisions based only on the appropriateness of care and/or service and the existence of coverage. We use Milliman Care Guidelines and BCBSNC corporate medical policy as guidelines for our decision-making. At no time does BCBSNC reward decision makers performing utilization review for issuing denials or reductions of coverage. BCBSNC does not have financial incentives that encourage decisions that result in underutilization of care and/or services.

Survey Respondent Wins Gift Check

We would like to thank all providers who took the time to complete the 2004 Provider Satisfaction Survey. For each response received, we will donate $1 to Be Active North Carolina, a statewide physical fitness initiative. Congratulations to Angela Ash from the office of James F. Kirk, DPM, Concord, N.C., as she is the winner of the $50 American Express gift check. Be on the lookout for the 2005 Provider Satisfaction Survey, which will be conducted this spring.

FEP Case Management – A Dedicated Team of Experts

Did you know that the Federal Employee Program (FEP) has a Case Management team that is dedicated to helping FEP members navigate the often confusing world of health care and obtaining the care that they need? Our FEP case managers are highly qualified registered nurses, with diverse clinical backgrounds and expertise. They serve as liaisons between FEP members and providers to assist in the coordination of medically necessary services tailored to the patient's needs. Case managers serve as a resource for both the member and the provider to help them utilize their FEP benefits to the maximum effect.

The work of FEP Case Management affects providers, members and ancillary services. Their diligent efforts to manage patient benefits help to achieve quality care, cost containment and a healthier population. The program is designed to provide assistance to members who have catastrophic or chronic care needs: i.e., a newly diagnosed diabetic; a 69-year old woman who has suffered a stroke; a 17-year old boy with a spinal injury as a result of an auto accident; a 45 year-old male in need of a liver transplant.

Designed to Enhance Patient Care

FEP Case Management is an accredited, no-cost, voluntary program. It enhances the quality of patient care, client safety aspects, and promotes provider/community/member education and empowerment. Case management may even provide benefits for services not normally covered under the patient's medical plan, depending on the member's specific needs.

BCBSNC FEP case managers are just a phone call away at **1-888-234-2415**. As a provider, if you feel that one of your FEP patients could benefit from case management services, simply contact us with a referral and we will be happy to assist you. Our hours of operation are 8 a.m. to 4:30 p.m.

When Is Case Management Appropriate

Case Management is available to FEP members when FEP is the primary insurer. Many referrals come to us when a patient has already sustained an injury, is in the middle of a health care crisis, or has been admitted to the hospital. If possible, the best time to refer a patient for case management is before any of these events occur. With proper education and discharge planning prior to an acute episode, we can work together to ensure positive, cost-effective outcomes for everyone involved in the health care process.

Attaining a proactive stance to managing health care needs is an evolving process, one that requires collaboration and communication. Case managers work together with providers at every level to achieve the member's optimum level of wellness and functional capability. FEP Case Management is an essential service that helps the patient, family and health care providers manage benefits efficiently and effectively.

Claims Filing Tips for the Federal Employee Program

When filing claims on behalf of your Federal Employee Program patients, please remember to:

- Indicate the patient's date of birth on the claim. The subscriber's date of birth should only be used if the subscriber is the patient. An incorrect date of birth will result in the claim being mailed back to you due to incorrect information.
- Provide the group provider contract on the claim form. Effective February 1, 2005, benefits for professional services are based on the group provider contract and not the individual performing provider.
- Include the full name, gender and other pertinent information requested on the claim form. Claims received with incorrect patient information may result in a delay in processing, a mailback to you, or even a claim denial.
- Use black and white claims when filing paper HCFA claims, as they are easier to read than red and white claims.

2004 Results of Medical Records, Facilities and Access to Care Reviews

In an effort to provide a safe environment in which our members may receive the quality health care they need in a timely manner, BCBSNC, in conjunction with our advisory groups, has established standards for medical records, facilities and access to care against which all primary care practices and all OB/GYN practices are measured at least every three years.

BCBSNC has established the following targets for compliance with each of these standards:

- **Medical Records:** 90 percent of primary care physicians will attain a score of at least 90 percent on the review.
- **Facility:** 96 percent of all physicians, both primary care and OB/GYN, will attain a score of 100 percent on the facility site review.
- **Access to Care:** 98 percent of all physicians will attain a score of 100 percent compliance with the access to care standards.

Since the standards were developed in 1994 and measurement began in 1995, we have seen a significant improvement in the results of our biannual reviews. Our network physicians have demonstrated an earnestness in their efforts to correct any deficiencies noted in the course of a review.

Medical Records Review

The 2004 reviews, conducted in 409 practices, resulted in 88.3 percent of the practices meeting or exceeding the goal of 90 percent. Among the practices reviewed, 101 (24.7 percent) were found to be in 100 percent compliance with all standards being monitored.

A medical record assessment is conducted in primary care practices with insufficient member volume to support a complete medical record review. Only 27 practices fell into this category in 2004. Of those, twenty-four scored 100 percent on the monitored standards. One practice did not meet the problem list standard and two did not demonstrate documentation of smoking, alcohol use and substance abuse.

In 2004, OB/GYN practices that provide primary care services were targeted to have full medical record reviews. Because this was a baseline year for OB/GYNs who previously had only a medical record assessment, the target was 85 percent of practices reviewed attaining an overall score of 85 percent. All of the 65 OB/GYN practices that were reviewed attained a score of at least 86 percent. OB/GYN practices performed as well or better than primary care practices on every indicator except completed problem lists. On that indicator, 94.8 percent of the primary care practices were in compliance, as compared to only 84.1 percent of the OB/GYN practices.

Facility Site Reviews

New, more descriptive facility standards distributed in 2003 were the basis of the 2004 facility site reviews. Overall, 86.3 percent of the primary and OB/GYN practices reviewed met the facility standards. With recommendations from both the Credentialing Committee and the Provider Advisory Group, the following standards, which are designed to ensure patient safety, were named as critical standards. Noncompliance could jeopardize a practice's participation in the network. These standards are:

- Restricted, biohazard or abusable materials (i.e.; drugs, needles, syringes, prescription pads and patient medical records including active, archived and those of deceased patients) are secured and accessible only to authorized office/medical personnel for safety and to protect patient confidentiality.
- Controlled substances are maintained in a locked container/cabinet. A record is maintained of use.
- There is a procedure for monitoring expiration dates of all medications in the office.
- Dedicated emergency kit is available which must include sufficient equipment/supplies to support life until patient can be moved to an acute care facility. (At a minimum, ambu bag and airway.)
- At least one staff member is certified in CPR or basic life support.
- Emergency procedures are in place and are periodically reviewed with staff members.
- Emergency medications and oxygen are available. (Emergency meds should include at a minimum aspirin, glucose gel, epi pen, and benadryl.)
- Emergency supplies are checked routinely for expiration dates. A log is maintained documenting the routine checks.

Access to Care Review

Of the 518 primary practice sites reviewed, 504 (97.3 percent) were found to be 100 percent compliant with the standards, excluding hours of operation. Practices are grouped for analysis of compliance with standards for obtaining a routine physical exam by those expected to

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BCBSNC Special Investigations Unit: Hot on the Trail of Insurance Fraud

Unfortunately, fraud is alive and well in the health insurance industry – costing anywhere from $35 billion to $60 billion a year, according to a leading industry group. The good news is that BCBSNC's Special Investigations Unit (SIU) is well-versed in the latest schemes, old tricks and various methods of health insurance fraud that are attempted against BCBSNC.

Last year, SIU uncovered more than $5.3 million in attempted fraud, and they're on track for about the same this year. When SIU cracks a case, there can be many different possible resolutions, including civil or criminal fines against the perpetrators, jail time or the decredentialing of a doctor. Their work helps insurance regulators, law enforcement and other insurers in the fight against white-collar crime.

How Do They Do It?

As with any police or detective work, SIU looks for unusual, irregular and recurring patterns that could indicate wrongful actions. They also rely on others – including other BCBSNC employees – to alert them. For example, a Customer Service representative may notice that the service provided on a claim doesn't match the type of provider, and turn it over to SIU. Or the North Carolina Medical Board might be looking into questionable activity by a physician and contact SIU to work the case together. Some of the most common methods of fraud and abuse against health insurers include:

- Providers billing for medical services that were never rendered or for more expensive services than were actually provided.
- Providers performing medically unnecessary procedures solely for the purpose of generating insurance payments.
- Members filing claims for services they didn't receive or medical supplies they didn't purchase.
- Providers billing for medical services that were actually performed by unlicensed or noncovered personnel.

"Rent-a-Patient" Scam

It's one of the biggest cases of health insurance fraud in the nation, and BCBSNC's Special Investigations Unit is playing a role in stopping it. Under a scheme known as "rent-a-patient," medical patients were paid to go to outpatient surgery centers on the West Coast for medically unnecessary and expensive procedures.

Organizers solicited patients to receive unnecessary surgeries and other procedures and lured them to travel to surgery clinics in the Los Angeles area for treatment. At the clinics, the patients were paid an average of about $800 per procedure to receive medically unnecessary colonoscopies, endoscopies, sweat-gland surgeries and other procedures. The clinics then submitted grossly inflated claims to health insurers across the country – including BCBSNC – which paid millions of dollars in reimbursements.

The FBI and other authorities have made arrests. SIU is assisting the FBI and other law enforcement agencies in the investigation. However, the investigation continues because of how far-reaching the scam appears to have become. Last year, *The Wall Street Journal* reported that insurers and employer groups had paid between $300 million and $500 million in claims associated with the scam.

As this issue went to print, BCBSNC joined 11 other Blue Plans in a $30 million lawsuit against the California-based providers, clinics and individuals involved in ths massive fraud scheme.

2004 Results of Medical Records, Facilities and Access to Care Reviews *(continued from page 6)*

treat an adult population (family practice and internal medicine) and those expected to treat a pediatric population (family practice and pediatrics). Family practices are counted in both categories for this analysis. Of the 428 practices expected to treat adults, 422 (98.6 percent) were in 100 percent compliance. Of the 355 practices expected to treat pediatric patients, 349 (98.3 percent) were found to be in compliance with the standards.

100 percent of the OB/GYN practices reviewed were found to be in 100 percent compliance with the standards. Also, translator services were found in 68 percent of primary practices and 66 percent of OB/GYN practices.

Wait Time = Patient Dissatisfier

Based on analysis of the Provider-Specific Member Satisfaction Survey, time in the waiting room continues to be a source of dissatisfaction to patients. This is perceived as not only the time in the actual waiting room, but also the time spent in a second waiting room or an exam room. We encourage you to not only move patients through the waiting room in a timely manner, but also limit, to any extent possible, their wait time in exam rooms.

State Health Plan Updates and Reminders

Correct Units on Psychotherapy Claims

When filing psychotherapy claims, please remember to put "1" in the unit field rather than the number of minutes. Putting the wrong number in the unit field causes us to incorrectly calculate the member's mental health visits. As a result, we are seeing a significant increase in the number of inquiries about whether a State Health Plan (SHP) member has or has not exceeded their 26 outpatient mental health visits. We are exploring how we might systematically catch these situations, but in the interim, claims are automatically denying because "1" was not indicated in the unit field.

Maternity and Newborn Inpatient Benefits

Maternity benefits are provided to enrolled female State Health Plan employees and enrolled female spouses. The mother must be enrolled in order to receive newborn well-baby benefits. Coverage for newborn care in the hospital (including well-baby pediatrician, well-baby nursery charges and circumcision) is a maternity benefit.

When a newborn requires special care as a sick baby, the care is no longer considered a maternity benefit. For benefits to be provided, the newborn must be enrolled in the State Health Plan effective the first day of the birth month. Pre-admission certification is required for the newborn that requires special care. Please remember the following when filing newborn inpatient claims:

- Put the newborn's name and date of birth on the claim.
- Use the ID number of the mother's policy.
- Once we receive the claim, we will transfer the charges to the mother's name if the newborn is determined to be a well baby. The charges will be posted to the mother's name on your Notification of Payment.
- If the newborn is determined to be a sick baby, charges will be posted under the baby's name, and the baby must be enrolled under the State Health Plan.

Remind SHP Members to Contact PHCS for Out-of-State Provider Information

Since 2003, the State Health Plan has contracted with Private Healthcare Systems (PHCS) to provide an out-of state provider network for SHP members and their dependents who receive medical services outside North Carolina. When referring State Health Plan members to an out-of-state physician or facility, please remind them to contact PHCS at **1-800-355-7610** to ensure that the referred physician or facility participates in the Healthy Directions network for the State Health Plan.

Initiating an Appeal or Grievance

When requesting an appeal or grievance on a patient's behalf, please use the State Health Plan-approved authorization form. This form specifies the exact dates and services the authorization is valid for. Requests must be received with proper authorization within 60 days of the original denial or the date of the benefit decision letter. This form may be obtained by calling State Customer Service at **1-800-422-4658** or by visiting our Web site at ***statehealthplan.state.nc.us***.

Staying Current with Diabetes Management

As the population of patients with diabetes or those prone to diabetes rises, keeping current with the American Diabetes Association (ADA) recommendations will be an important part of every medical practice. New additions to the Standards of Medical Care in Diabetes include prevention of type 2 diabetes and managing diabetes in hospitals. The ADA has expanded their discussion on medical nutrition therapy and has recommended aggressive lipid-lowering therapy for many patients with diabetes. The new recommendations can be viewed at www.diabetes.org.

Reminder About Chiropractic Benefits

State Health Plan members have chiropractic benefits limited to $2,000 each Plan year for covered services. Services are limited to the alignment of the spine, release of pressure by manipulation, modalities and X-rays of the spine. Chiropractors are not eligible to provide medications, drugs or nutritional supplements. If foot orthotics or other appliances are needed, they must be purchased from a durable medical equipment supplier.

How Far Back Will SHP Go For a Refund Request?

In the past, there was no limitation on how far the SHP would go back to pursue a refund. But as of last November, the State Health Plan will no longer pursue any overpayments that exceed two years. That time frame is calculated by date of identification to date of payment. This time frame is for a standard refund request only, and it does not apply to fraudulent, misuse or abusive filings. We will accept unsolicited provider refunds within any time frame.

Claims Must Be Submitted Within 18 Months

The State Health Plan requires that all claims for covered services be submitted within 18 months from the date of service in order to be considered for payment. Whenever the State Health Plan is the secondary carrier and the timely filing period is approaching, you should go ahead and submit the claim to us without the other carrier's Explanation of Benefits. Although the claim will deny, we will have a record that the claim was submitted within the 18-months timely filing limit. We will be able to

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process the claim in this situation even if the primary carrier's payment is received after 18 months.

NC Health Choice Enrollment Continues to Grow

NC Health Choice, the State of North Carolina's health insurance program for children, was established October 1, 1998. The program, administered by Blue Cross and Blue Shield of North Carolina (BCBSNC) through the State Health Plan, provides health care coverage for uninsured children whose families do not qualify for Medicaid. Currently, there are over 119,000 children enrolled in the program.

Covered services and supplies provided to NC Health Choice members are reimbursed based upon the allowable amounts established by the BCBSNC CostWise®[1] program. If a provider does not participate in CostWise or other programs through BCBSNC, and elects to treat NC Health Choice members, the member cannot be billed for any amount other than the applicable copayment. This is in accordance with the provisions of North Carolina General Statute 108A.70.21.b. that states "all health care providers rendering services to NC Health Choice members shall accept the maximum allowable charges under The North Carolina Teachers and State Employees Comprehensive Major Medical Plan." Members may be billed for services that are not covered by NC Health Choice.

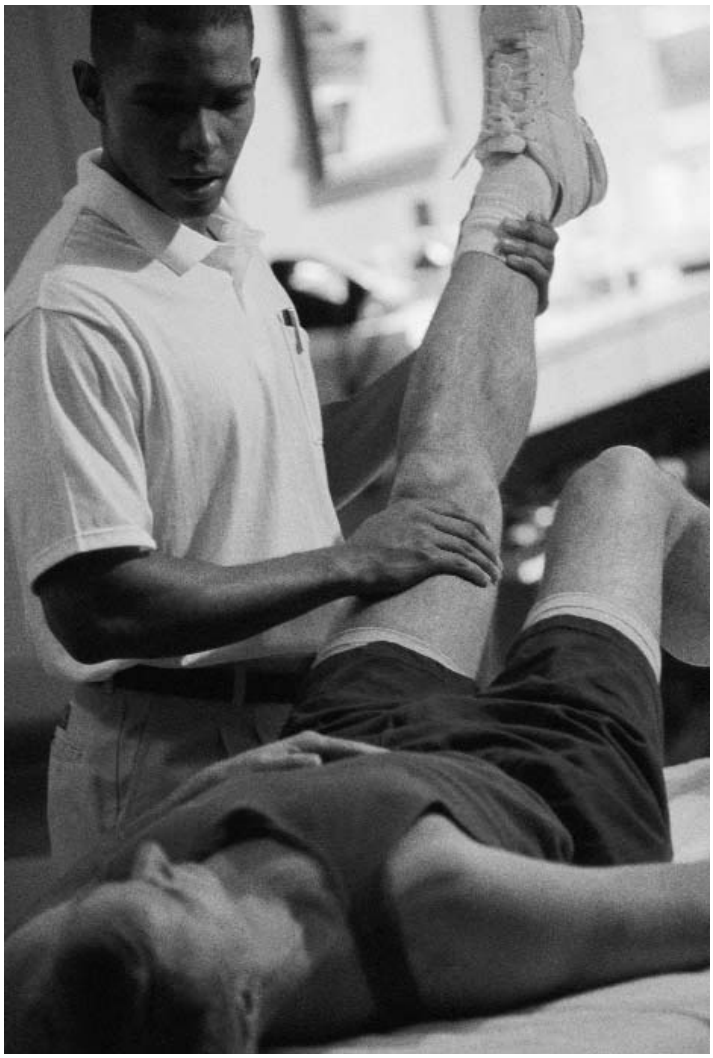
We continue to see an increase in the number of providers participating in the NC Health Choice program, and that participation is greatly appreciated by North Carolina's children and families. Please allow us to take this opportunity to thank you for supporting NC Health Choice. We look forward to working with you in 2005.

Retrospective Prior Approvals

Effective January 2, 2004, the State Health Plan made a change to its retrospective prior approval policy. Now, in order for a claim to be considered for retrospective review, requests must be received within six months (180 days) of the end date of service. Requests received after 180 days of the end date of service will be denied even if the services were provided in the appropriate setting and met medical necessity criteria as defined by the State Health Plan.

Physical Therapy and Occupational Therapy

The State Health Plan allows benefits for physical therapy and occupational therapy on the same day, limited to one hour each. However, the physical therapy must be rendered by a licensed physical therapist, and the occupational therapy must be rendered by a licensed occupational therapist. This distinction must be clearly identifiable on the claim.



2005 Facility Care Standards for HMO/POS/PPO Providers

BCBSNC, in conjunction with our Physician Advisory Group, has expanded the standards for facilities of practices participating in our managed care programs. Facility care standards are used in the assessment of the environment in which health care is provided to our members. New standards for 2005 deal predominantly with patient safety and the practices' ability to render emergency care if necessary.

1. The general appearance of the facility provides an inviting, organized and professional demeanor including, but not limited to, the following:
   a. The office name is clearly visible from the street.
   b. The grounds are well maintained; patient parking is adequate with easy traffic flow.
   c. The waiting area(s) are clean with adequate seating for patients and family members.
   d. Exam and treatment rooms are clean, have adequate space and provide privacy for patients. Conversations in the office/treatment area should be inaudible in the waiting area.
2. There are clearly marked handicapped parking space(s) and handicapped access to the facility.
3. A smoke-free environment is promoted and provided for patients and family members.

4a. (formerly 4b) A fire extinguisher is clearly visible and is readily available.

4b. (formerly 4c) Fire extinguishers are checked and tagged yearly.

5. There is a private area for confidential discussions with patients.
6. Health-related materials are available (i.e.; patient education, office and insurance information is displayed).
7. Designated toilet and bathing facilities are easily accessible and equipped for the handicapped (i.e.; grab bars).

8a. There is an evacuation plan posted in a prominent place or exits are clearly marked, visible, and unobstructed.

8b. There is an emergency lighting source.

9. Halls, storage areas and stairwells are neat and uncluttered.
10. There are written policies and procedures to effectively preserve patient confidentiality. The policy specifically addresses 1) how informed consent is obtained for the release of any personal health information currently existing or developed during the course of treatment to any outside entity, i.e.; specialists, hospitals, third party payers, state or federal agencies; and 2) how informed consent of release of medical records, including current and previous medical records from other providers which are part of the medical record, is obtained.

*11a. Restricted, biohazard or abusable materials (i.e.; drugs, needles, syringes, prescription pads and patient medical records) are secured and accessible only to authorized office/medical personnel. Archived medical records and records of deceased patients should be stored and protected for confidentiality.

*11b. Controlled substances are maintained in a locked container/cabinet. A record is maintained of use.

*11c. There is a procedure for monitoring expiration dates of all medications in the office.

*12a. At least one staff member is certified in CPR or basic life support.

*12b. Emergency procedures are in place and are periodically reviewed with staff members.

*12c Emergency supplies include, but are not limited to, emergency medications, oxygen, mask, airway and ambu bag.

*12d. Emergency supplies are checked routinely for expiration dates. A log is maintained documenting the routine checks.

13. There is a written procedure, which is in compliance with state regulations for oversight of mid-level practitioners.
14. There is a procedure for ensuring that all licensed personnel have a current, valid license.

15a. A written infection control policy/program is maintained by the practice.

15b. There is periodic review and staff in-service on infection control.

15c. Sterilization procedures and equipment are available.

Note: Standards preceded by an asterisk * are critical elements. Failure to comply with any of these (numbers 11 and 12 inclusively) could result in a shortened credentialing cycle or possible removal from the BCBSNC provider network.

2005 Access to Care Standards for Primary Care Physicians/Specialists

BCBSNC and its Physician Advisory Group have established the following access to care standards for primary care physicians and when noted, specialists, including non-MD specialists. Non-MD specialists are chiropractors (DC), podiatry (DPM), physical therapy (PT), speech therapy (ST), and occupational therapy (OT).

EMERGENT CONCERNS (LIFE THREATENING) SHOULD BE REFERRED DIRECTLY TO THE CLOSEST EMERGENCY DEPARTMENT. IT IS NOT NECESSARY TO SEE THE PATIENT IN THE OFFICE FIRST.

Waiting time for appointment (number of days):	
Urgent - not life threatening, but a problem needing care within 24 hours (Applies to both primary care physicians and specialists): Pediatrics and Adults: See within 24 hours	**Symptomatic non-urgent:** e.g., cold, no fever Pediatrics and Adults: within 3 calendar days
Regular (Applies to specialists only): Pediatrics: within 2 weeks Adults: within 2 weeks for sub-acute problem of short duration and within 4 weeks for chronic problems.	**Follow-up of Urgent Care:** Pediatrics and Adults: within 7 days
Chronic care follow-up: e.g., blood pressure checks, diabetes checks Pediatrics and Adults: within 14 days	**Complete Physical/Health Maintenance:** Pediatrics: within 30 calendar days Adults: within 60 calendar days

Time spent in waiting room (A and C apply to both primary care physicians and specialists):

(A) Scheduled	30 minutes After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment. The maximum waiting time is 60 minutes.
(B) Walk-ins (primary care physicians only)	BCBSNC discourages walk-ins, but reasonable efforts should be made to accommodate patients. Life-threatening emergencies must be managed immediately.
(C) Work-ins	(Called that day prior to coming) After 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling. The maximum waiting time is 90 minutes.

Response time returning calls after-hours (Applies to both primary care physicians and specialists):

***Urgent** 20 minutes | **Other** 1 hour

* NOTE: Most answering services cannot differentiate between urgent and non-urgent. Times indicated makes assumption that the member notifies the answering service that the call is urgent and that the physician receives enough information to make a determination.

Office Hours (Indicates hours during which appropriate personnel is available to care for members, i.e.; MD, DO, FNP, PA.):

Daytime hours/weeks	Primary Care Physicians: 7 hours per day x 5 days = 35 hours Specialists: 15 hours minimum a week, covering at least 4 days
Nighttime hours/week	Optional, but encouraged
Weekend hours/week	Optional, but encouraged

Specialist Hours of Availability:

Daytime hours/weeks 40 hours a week | **Nighttime hours/week** 24-hours a day coverage of some sort

A clear mechanism to convey results of all lab/diagnostic procedures must be documented and followed. An active mechanism (i.e.; not dependent on the patient) to convey abnormal values to patients must be documented and followed.

BCBSNC Member Rights and Responsibilities

We feel that it is important for you to be aware of the member rights and responsibilities that we share with our members on an annual basis. The following information outlines our expectations regarding how our members should interact not only with us, their health insurer, but also with you, their provider of health care services, and in turn, how we should interact with them.

As a Blue Cross and Blue Shield of North Carolina (BCBSNC) member, you have the right to:

- Receive information about your coverage and your rights and responsibilities as a member.
- Receive, upon request, facts about your plan, including a list of doctors and health care services covered.
- Receive polite service and respect from BCBSNC.
- Receive polite service and respect from the doctors who are part of the BCBSNC networks.
- Receive the reasons why BCBSNC denied a request for treatment or health care service, and the rules used to reach those results.
- Receive, upon request, details on the rules used by BCBSNC to decide whether a procedure, treatment, site, equipment, drug or device needs prior approval.
- Receive, upon request, a copy of BCBSNC's list of covered prescription drugs. You can also request updates about when a drug may become covered.
- Receive clear and correct facts to help you make your own health care choices.
- Play an active part in your health care and discuss treatment options with your doctor without regard to cost or benefit coverage.
- Participate with practitioners in making decisions about your health care.
- Expect that BCBSNC will take measures to keep your health information private and protect your health care records.
- Complain and expect a fair and quick appeals process for addressing any concerns you may have with BCBSNC.
- Make recommendations regarding BCBSNC's member rights and responsibilities policies.
- Receive information about BCBSNC, its services, its practitioners and providers and members' rights and responsibilities.
- Be treated with respect and recognition of your dignity and right to privacy

As a BCBSNC member, you should:

- Present your BCBSNC ID card each time you receive a service.
- Read your BCBSNC benefit booklet and all other BCBSNC member materials.
- Call BCBSNC when you have a question or if the material given to you by BCBSNC is not clear.
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, advise your doctor.
- Provide BCBSNC and your doctors with complete information about your illness, accident or health care issues, which may be needed in order to provide care.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Make appointments for non-emergency medical care and keep your appointments. If it is necessary to cancel an appointment, give the doctor's office at least 24-hours notice.
- Play an active part in your health care.
- Be polite to network doctors, their staff and BCBSNC staff.
- Tell your place of work and BCBSNC if you have any other group coverage.
- Tell your place of work about new children under your care or other family changes as soon as you can.
- Protect your BCBSNC ID card from improper use.
- Comply with the rules outlined in your member benefit guide.

Updates From EDI Services

Blue *e* Returns Information From Blue Plans Around the Country

Coming this April, you may use **Blue *e***℠ to inquire about subscribers of Blue Cross and Blue Shield (BCBS) Plans in other states. This functionality applies to eligibility inquiries and claim status requests. New functionality offered by the Blue Cross and Blue Shield Association (BCBSA) allows easier sharing of information about BCBS subscribers across the country – no matter what specific BCBS Plan administers their policy.

Blue *e* users will notice slight modifications to the Health Eligibility and Claim Status Inquiry input screens as this new service is implemented in April. Inquiries that apply to subscribers within North Carolina will not change. Inquiries for BlueCard® members that are to be sent to other Blue Plans may need a few additional pieces of information to allow us to use the BCBSA's service. Keep an eye on your **Blue *e*** "What's New" page for more information about this new service.

Get the Details in Your Eligibility Responses

As of December 12, 2004, your HIPAA (270) batch inquiry for a patient's eligibility returns copayment, coinsurance and deductible information in the response. This greater level of detail gives you more information with which to project account balancing and remittances.

LPF Claim Format Retires This July

Most health care providers have already made the transition to HIPAA-compliant formats for their health care claims. Those who have not yet made the move should be aware that, after July 2005, BCBSNC will no longer accept the old format. All providers will be expected to be able to submit HIPAA-compliant institutional (formerly UB92) and professional (formerly HCFA) claims. See the "EDI Services" section of the "I'm a Provider" page at ***bcbsnc.com*** for contact and HIPAA information, or call EDI Customer Support at **1-888-333-8594**.

Relationship Code Requirements

As of March 12, 2005, BCBSNC began requiring that the X12 "Patient Relationship to Insured" code be used for ALL formats of institutional or UB92 claims. Use the X12 relationship codes in the UB92 Field Locator 59 when filing institutional claims. This change is regardless of the date of service. The X12 Patient Relationship Code should be used for **Blue *e***, the BCBSNC local proprietary format (LPF), HIPAA ANSI 837-Institutional transactions, and claims filed on paper. These relationship codes, listed in the table below, became effective October 16, 2003.

X12 Code	Description	X12 Code	Description
01	Spouse	24	Dependent of Minor Dependent
04	Grandfather or Grandmother	29	Significant Other
05	Grandson or Granddaughter	32	Mother
07	Nephew or Niece	33	Father
10	Foster Child	34	Other Adult
15	Ward	36	Emancipated Minor
17	Stepson or Stepdaughter	39	Organ Donor
18	Self	40	Cadaver Donor
19	Child	41	Injured Plaintiff
20	Employee	43	Child Where Insured Has No Financial Responsibility
21	Unknown	53	Life Partner
22	Handicapped Dependent	G8	Other Relationship
23	Sponsored Dependent		

(Continued on page 14)

Correct Your Professional (837) Claims Electronically

Corrected professional 837 claims should be submitted electronically using one of the Frequency Type Codes in the 2300 CLM05:3 element listed below. Submitting corrected claims electronically improves turn-around time and relieves you of the need to file paper. Remember - electronically corrected 837 professional claims do not need to be submitted on paper.

Value	Code Title	Definition
5	Late Charges Only	This code is to be used for submitting charges to the payer that were received by the provider after the Admit Through Discharge for the last interim claim has been submitted. However, providers should not use this code in lieu of an adjustment claim or a replacement claim.
7	Replacement of Prior Claim	This code is to be used when a specific bill has been issued for a specific provider, patient, payer, insured and "Statement Covers Period" and it needs to be restated in its entirety, except for the same identifying information. In using this code, the payer is to operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill. However, providers should not use this code in lieu of a late charge(s) only claim.
8	Void/Cancel of Prior Claim	This code reflects the elimination in its entirety of a previously submitted bill for a specific provider, patient, payer, insured and "Statement Covers Period" dates. The provider may wish to follow a void bill with a bill containing the correct information when a payer is unable to process a replacement to a prior claim. The appropriate frequency code must be used when submitting the new bill.

Please note that Value 6 is no longer a valid code within the Frequency Type Code set.

ClaimCheck Version 34 Available to Blue *e* Users

House Bill 1066, enacted into law during the 2003 session of the North Carolina General Assembly, amended Article 3 of Chapter 58 of the North Carolina General Statutes by adding a new section, NCGS 58-3-227. This bill requires health plans to disclose descriptions of their claim submission and reimbursement policies to participating (contracting) providers and to make fee schedules available to participating providers and providers to whom they offer a contract.

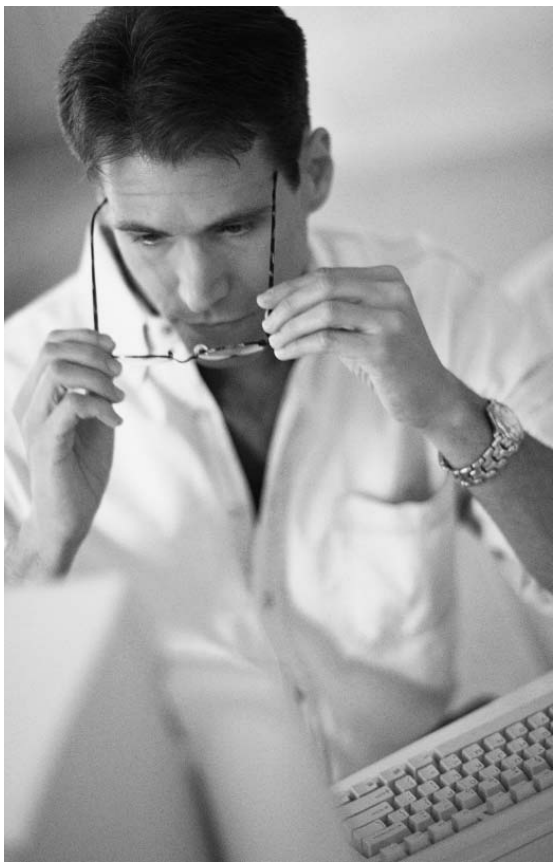
As a result, version 34 of ClaimCheck is now available for viewing purposes only (as of March 12, 2005). This application is available to all Blue *e* contracting providers through your current Blue *e* application and Clear Claim Connection. ClaimCheck software discloses BCBSNC code auditing rules and associated clinical rationale for the following BCBSNC products for which health care claims are processed on BCBSNC's New Blue (PowerMHS) claims adjudication system:

- Classic Blue®
- Blue Options
- Blue Choice
- Blue Care
- Blue HMO℠
- Blue Advantage®
- Blue Assurance℠
- Access℠[1]
- Retired Military
- Group Conversion
- Short Term

Version 34 will move to production May 12, 2005, and will be used for claims adjudication after this date. Version 32 will remain available for viewing purposes for 60 days after the new version goes live in May.

If you have any questions regarding Clear Claim Connection, please contact your local BCBSNC Network Management office for more information.

Register Online for Spring Physician and Hospital Workshops



Blue Cross and Blue Shield of North Carolina (BCBSNC) invites you to attend one of our spring health care provider workshops. In addition to the physicians' office staff workshops, we will offer a separate workshop for the hospital community.

Our workshops provide you with updates and information on new and exciting initiatives at BCBSNC, as well as a review of current procedures for claims submission. Our products are now easier to use, with improved electronic processes and simplified policies to help you with your day-to-day business with us. Additionally, we will distribute the *2005/2006 Physician Office Guide* at the workshops.

Our partnership with you is important. We want to assist you by providing updates to the work that we do, so you are better informed and able to provide quality health care services to BCBSNC members. Please plan to attend a workshop this spring in your area, so you can get the latest information.

With Cvent, you can register online for either a BCBSNC physicians' office staff or hospital workshop. Just log on to ***https://guest.cvent.com*** and enter the event code (listed below) for the location and date that is most convenient for you. You will receive an immediate confirmation. Workshop space is limited in some locations, so registering online is the fastest and preferred way to reserve your seat. We look forward to seeing you at a BCBSNC provider workshop this spring!

Date	Cvent Code	City	Location
May 17	4VNE7NW3CFA	Fayetteville	Holiday Inn - I95
May 18	7EN4LHSEQ83	Raleigh/Durham	RTP Hilton
May 19	4UN6K2AFAMV	Elizabeth City*	Hampton Inn
May 25	4JNTRMPJL7H	Wilmington	UNCW Executive Center
May 26	7FN7F7935WY	Greenville	Greenville Hilton
June 7	7GNMJASU9PP	Greensboro	Holiday Inn - Airport
June 8	4NNA8EGQYA8	Winston-Salem	Adams Mark Hotel
June 9	7JNWH98QAZR	Salisbury*	Holiday Inn
June 14	64N46HHXZUD	Charlotte	Embassy Suites
June 15	7ZNKEVMTKQ8	Asheville	Renaissance Asheville Hotel
June 16	6HNPTKAPM75	Hickory*	Park Inn

*Elizabeth City, Salisbury and Hickory will not have hospital workshops or afternoon physician workshop sessions.

Rx Corner

Prescription Drug Benefit Updates

Zantac/ranitidine

As of March 8, 2005, BCBSNC no longer covers Zantac or its generic equivalent, ranitidine, at the 150 mg strength. This change is based on the U.S. Food and Drug Administration's recent decision to make the 150 mg strength of Zantac (ranitidine) available as an over-the-counter (OTC) medication. BCBSNC's prescription drug benefits do not cover OTC medications.

If ranitidine 150 mg is appropriate for your patients, please suggest that they purchase it over-the-counter. The brand name of the nonprescription product is Maximum Strength Zantac 150.

Topical Antifungal Agents

Effective February 1, 2005, BCBSNC no longer covers the following drug products, as they are available over-the-counter:

- Monistat-Derm (topical miconazole)
- Lotrimin (topical clotrimazole)
- Mentax (butenafine cream)

OTC medications are generally much less expensive for members than their prescription counterparts. Please recommend that your patients purchase these OTC products as required for the appropriate fungal skin infections.

Download Epocrates Rx

Did you know that the BCBSNC clinical formulary can now be downloaded to your PDA? Epocrates Rx is a software program that can be easily downloaded free of charge for use on Palm OS and Pocket PC PDAs. This electronic drug reference lists over 3,300 brand and generic drugs, as well as BCBSNC - specific formulary information. You can also stay informed with FDA warnings and drug updates and find out about specific drug-to-drug interactions.

For more information about Epocrates Rx, just follow the "Download Formulary to PDA" link under our "Find a Drug" section at ***bcbsnc.com***. You can also go straight to ***epocrates.com***.

New Generic Drugs = Lower Copayments for Members

The following drug products have recently become available generically and are available at the lowest copayment level (Tier 1) for BCBSNC members. Remember to tell your patients that the FDA requires that generic drugs have the same quality, strength, purity and stability as their brand-name counterparts. Prescribe generic drug products when appropriate for your patients and help them save money on their out-of-pocket prescription drug costs.

New Generics – Tier 1 (Lowest Copayment)		
Brand Name:	**Generic Name:**	**Therapeutic Class:**
Uniphyl	theophylline extended-release	Pulmonary Agents
Terazol	terconazole vaginal cream	Vaginal Antifungals
Zyban	bupropion sustained-release	Smoking Deterrents
Cipro	ciprofloxacin	Quinolones
Synthroid	levothyroxine	Thyroid Hormones
Diflucan	fluconazole	Antifungal Agents
Mycelex Troche	clotrimazole troche	Antifungal Agents
Lopressor HCT	metoprolol/hydrochlorothiazide	Combination Antihypertensives
Miralax powder for oral solution	polyethylene glycol 3350	Bowel Evacuants
Neurontin	gabapentin capsules/tablets	Anticonvulsants
Glucophage XR 750 mg	metformin extended-release	Diabetes Therapy
Celexa	citalopram	Antidepressants
Plendil	felodipine	Calcium Channel Blockers
Pletal	cilostazol	Antiplatelet Drugs
Accupril	quinapril	ACE Inhibitors
Duragesic	fentanyl transdermal patch	Narcotic Analgesics

(continued on page 17)

Tier-to-Tier Changes for BCBSNC Drug Formulary

Over the last several months, Blue Cross and Blue Shield of North Carolina and its Pharmacy and Therapeutics Committee have reviewed the following new drug products and made the following decisions regarding their formulary tier (copayment) placement.

Tier 2 – Preferred Brands (Second Lowest Copayment)

Brand Name	Generic Name	Therapeutic Class
Aceon	perindopril	ACE Inhibitors
Mavik	trandolapril	ACE Inhibitors
Uniretic	moexipril/hydrochlorothiazide	Combination Antihypertensives
Wellbutrin XL	bupropion sustained-release	Antidepressants
Spiriva	tiotropium bromide	Pulmonary Agents
Sensipar	cinacalcet	Miscellaneous Hormones
Cleocin Ovules	clindamycin vaginal suppository	Vaginal Anti-Infectives
Elidel	pimecrolimus cream	Miscellaneous Dermatologicals
Vytorin	ezetimibe/simvastatin	Lipid-Lowering Agents
Epzicom	abacavir/lamivudine	HIV/AIDS Therapy
Truvada	emtricitabine/tenofovir	HIV/AIDS Therapy
Pulmicort Turbuhaler	budesonide	Inhaled Corticosteroids
Creon	amylase/lipase/protease	Digestive Enzymes
Pancrease	amylase/lipase/protease	Digestive Enzymes
Ultrase	amylase/lipase/protease	Digestive Enzymes
Ku-zyme	amylase/lipase/protease	Digestive Enzymes
Viokase	amylase/lipase/protease	Digestive Enzymes

Tier 3 – Non-Preferred Brands (Highest Copayment)

Brand Name	Generic Name	Therapeutic Class
Uroxatral	alfuzosin	BPH Therapy
Namenda	memantine	Miscellaneous Neurological Therapy
Elestat	epinastine ophthalmic	Miscellaneous Ophthalmologics
Pravigard PAC	pravastatin + aspirin	Lipid-Lowering Agents
Estrasorb	estradiol emulsion	Estrogens
Estrogel	estradiol gel	Estrogens
Prevacid NapraPAC	lansoprazole + naproxen	Proton Pump Inhibitors
Crestor	rosuvastatin	Lipid-Lowering Agents
Caduet	atorvastatin/amlodipine	Lipid-Lowering Agents
Inspra	eplerenone	Diuretics
Symbyax	olanzapine/fluoxetine	Miscellaneous Antipsychotics
Myfortic	mycophenolic acid	Immunosuppressant Drugs
Climara Pro	estradiol/levonorgestrel patch	Estrogen Combinations
Ertaczo	sertaconazole cream	Topical Antifungals
Niaspan	niacin extended-release	Lipid-Lowering Agents
Nutropin/AQ	somatropin injection	Growth Hormone

Want to take a faster path to payment for your Blue Cross and Blue Shield of North Carolina claims?

What about...

- Getting 90% of your BCBSNC claims paid within 10 days?
- Receiving confirmation immediately that all your payers have your claims?
- Fixing errors immediately before the claim reaches the payer?
- Reducing your volume of pended and denied claims?
- Being fully HIPAA compliant, without spending thousands of dollars?
- Submitting and receiving claims, eligibility and ERA's from one online site?
- Easily tracking, trending and correcting recurring billing errors?

BCBSNC is always on the lookout for new ways to speed and simplify the claims filing process for our participating physicians and other health care providers. That's why we're excited to announce that physician practices of all sizes can take advantage of instantaneous, electronic claim submission under an innovation developed by RealMed, a business partner of BCBSNC.

Call RealMed today at **1-877-REALMED** or visit ***www.realmed.com*** to find out how easy and affordable it is to submit all claims to all payers, verify eligibility and claim status, automatically check errors, adjudicate claims, receive remittance and eliminate your paper - all while being HIPAA compliant.

Listen to what some of RealMed's North Carolina clients are saying...

"**The best I've seen!** I am done with guessing what is wrong with my claims. RealMed edits my claims and has me on my way to payment in no time. Thank you for simplifying our insurance processing!"

Administrator
Sylvan Valley OB/GYN
Brevard, NC

"**RealMed has made a huge difference** in the time spent trying to figure out which claims made it to the payer and which ones didn't. Our claims representative literally would be tied up for hours... RealMed lets us know almost immediately."

Office Manager
Capitol Ear, Nose & Throat (ENT)
Raleigh, NC

"**RealMed is the best advance in claims processing** that I have seen in 20 years of private practice. RealMed has decreased our average reimbursement time by 50%. Client support has been pleasant, knowledgeable, prompt and reliable."

Practicing Physician
Greater Carolina Women's Center
Charlotte, NC

"**I have only the highest accolade for RealMed.** It is indeed 'The Fastest Path to Payment.' Gone is a lot of the mundane, repetitive work of insurance billing. My co-workers and I are able to accomplish so much more during the workday by being able to so readily access the information we need to 'get it right' the first time on our claims."

Billing Manager
Wilmington Medical Group
Wilmington, NC

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to take advantage of a limited time offer!

Medicaid Claim Filing Reminder

Claims submitted to Blue Cross and Blue Shield of North Carolina (BCBSNC) by the North Carolina Medicaid Program (Medicaid) from a participating provider will be returned to the provider. In accordance with our member certificates and our contract with you, a participating provider, you are required to file a claim for these services directly to BCBSNC.

Once we receive your claim, we will process it in accordance with the member's benefit coverage and our contractual obligations to you. If you have a patient who is a Medicaid beneficiary and if you do not know if the patient has BCBSNC coverage, you may make an inquiry using Blue *e*SM.

Upon receipt of payment from BCBSNC, Medicaid requires that you reimburse Medicaid for the lesser of either Medicaid's payment or BCBSNC's payment for the services in question. If you have questions as to whether you need to reimburse Medicaid, please contact Medicaid directly.

New Contact Information for BCBSNC Appeals

In order to streamline the provider inquiry process, a Provider Resolution Unit has been established within our Member Rights and Appeals Department. Effective April 1, 2005, all member-specific inquiries for processed claims with dates of service on or after April 1, 2005, and which **pertain to coding, bundling/unbundling and fees,** should be directed to:

BCBSNC Provider Resolution Unit
P.O Box 30055
Durham, NC 27702

Or you can fax your inquiries to us at:
1-919-765-4409

All other inquiries should continue to be sent to:

BCBSNC Customer Services
P.O Box 2291
Durham, NC 27702

A separate provider inquiry form for requesting reviews for medical necessity, coding, unbundling and fees issues is currently under development and will be available soon on the BCBSNC Web site at ***bcbsnc.com*** under the "I'm a Provider" section.

Obesity Benefit Change Reminder

In support of the Member Health Partnerships℠ -- Healthy Lifestyle Choices℠ program, coverage for four physician office visits per year and related testing for the evaluation and treatment of obesity will be available beginning April, 1, 2005, or at a BCBSNC member's group renewal date. Benefits for members covered under Blue Options or Blue Care will begin at the group's renewal date. Benefits for members who have individual coverage under Blue Advantage® will begin January 1, 2006. Both adults and children will be eligible for these benefits.

Obesity codes designated in the 278 category in the ICD-9-CM will now be covered. Please note that the fourth and fifth digits should be reported.

BlueCross BlueShield of North Carolina

BlueLINK

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Plans Already Underway for 2005 Free Flu Shot Initiative

As we say "so long" to this winter's flu season, Blue Cross and Blue Shield of North Carolina (BCBSNC) is already making plans for another immunization drive this fall. Similar to our planned flu shot initiative in 2004, we will provide free flu shots to all eligible BCBSNC members at clinics located throughout the state and at many large employer work sites.

We will also be reminding our members that, in most cases, members with preventive health benefits may receive a flu shot from their physician at no cost to them. We'll share more details about BCSBNC's 2005 flu shot initiative with you in future issues of *Blue Link* as plans for the fall immunization drive develop.