BlueLINK℠

News from Blue Cross and Blue Shield of North Carolina

Fall 2004

Volume No. 9, Issue No. 3

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BlueCross BlueShield of North Carolina

Influenza Vaccine Information and Recommendations

(P) (F)

Recent published recommendations[1] on influenza vaccinations from the Advisory Committee on Immunization Practices (ACIP) include the following changes or updates for the 2004-2005 influenza season:

- Vaccinations are now recommended for all healthy children ages 6 to 23 months and for close contacts of children ages 0 to 23 months.
- Inactivated vaccines (injections) are preferred over live, attenuated influenza vaccines (nasal) for household members, health care workers and all other close contacts of severely immunosuppressed patients.
- The 2004-2005 trivalent vaccine contains virus strains A/Fujian/411/2002 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Shanghai/361/2002-like antigens or antigen equivalents.

Children younger than 9 years of age who are receiving the influenza vaccine for the first time should receive two doses of the vaccine. If their first vaccination is with the inactivated vaccine (injectable), the two doses should be administered at least one month apart. Children ages 5 to 8 who are receiving their first vaccination with the live, attenuated vaccine (nasal) should receive the two doses at least six weeks apart.

Approved Influenza Vaccines for Different Age Groups

Vaccine	Route	6 mos - 3 yrs.	4 years	5 - 49 yrs.	50 yrs. and older
FluZone® (Aventis Pasteur, Inc.)	Intramuscular	X*	X	X	X
Fluvirin™ (Chiron)	Intramuscular		X	X	X
FluMist™ (MedImmune, Inc.)	Nasal			X	

*Children ages 6 to 35 mos. should receive 0.25 ml/dose. Children older than 35 mos. should receive 0.5 ml/dose.

The optimal time to administer the influenza vaccination is October and November. Previously unvaccinated children should receive their first vaccine dose in October or earlier in order to complete vaccination before influenza season starts. Unvaccinated children and adults can continue to receive vaccine up to and during influenza outbreaks.

(Continued on page 2)

BCBSNC Plans Transition to New Member ID Numbers

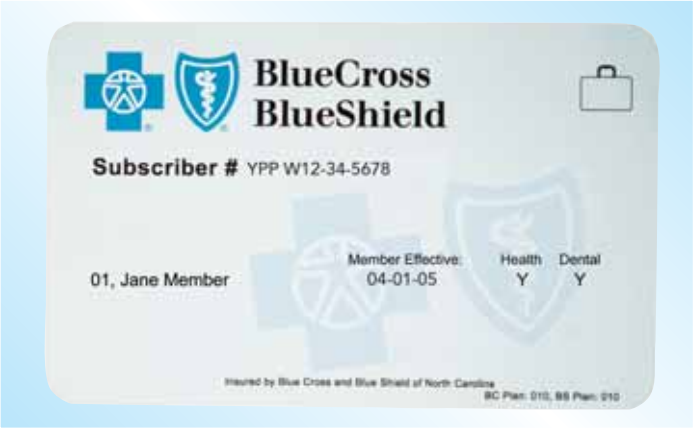
Over the course of the past year, we have been informing you of our plan to gradually convert our members' identification numbers from their Social Security number (SSN) to a non-SSN-based ID number. These changes are being made in an effort to protect our members against identity theft and respond to the national trend to stop the display of the SSN on ID cards.

In 2005, Blue Cross and Blue Shield of North Carolina (BCBSNC) will begin to replace all SSN-based ID numbers on member ID cards and correspondence. Beginning in April 2005, we will start issuing new ID cards with the new number for groups that renewed in February, March or April. We will continue issuing new ID numbers upon group renewal dates through January 2006.

This schedule means that all BCBSNC members will have new identifiers by the end of January 2006. All member ID cards – as well as correspondence with members and providers – will contain the new identifiers. The following schedule outlines the planned conversion to the new numbers (please note that this plan is subject to change):

- **Commercial Group Members – Beginning 4/01/05 with completion by 1/01/06**
- **Medicare Supplement Members – 4/01/05**
- **State Health Plan Members – 7/01/05**
- **Individual Products (Blue Advantage®, etc.) – 1/01/06**

The proposed new subscriber ID number will consist of a lead alpha character (W), followed by eight numeric digits. The current prefixes and suffixes (dependent numbers) used today will not be affected. For example, if a three-digit prefix and two-digit suffix is part of the current subscriber ID (YPP-SSN# - 01), the same prefixes and suffixes will be used with the new ID number (YPP - W12345678 - 01). Here is an example of what a 2005 ID card will look like:



Please ensure that your systems and your vendor's systems can accommodate the new number format. Also, please ask your patients to present their new ID card so that you can update your records with the new ID number. For more information, you can go to ***bcbsnc.com*** and click on "Important News" on the "I'm a Provider" home page.

Influenza Vaccine Information and Recommendations *(continued from page 1)*

Vaccination is recommended for all individuals who desire it. However, according to the ACIP, the primary target groups recommended for annual vaccination are:

1) People at risk for influenza-related complications (e.g., those 65 years or older, children ages 6 to 23 months, pregnant women, and people of any age with certain chronic medical conditions including chronic disorders of the cardiovascular or pulmonary system, diabetes, renal dysfunction, hemoglobinopathies, and congenital or acquired immunosuppression caused by underlying disease or immunosuppressive therapy).

2) People ages 50 to 64 years, as this group has an elevated prevalence of certain chronic medical conditions.

3) People who live with or care for persons at high risk (e.g., health care workers and household contacts who have frequent contact with persons at high risk and who can transmit influenza to them).

The injectable inactivated vaccine is recommended for all patients at high risk for influenza complications. **Nasally administered live, attenuated vaccine (FluMist) is NOT indicated for use in groups of patients who are at high risk such as those described in 1 and 2 above.**

FluZone and Fluvirin are available in multi-dose vials or prefilled syringes and must be refrigerated (not frozen). The multi-dose vials contain thimerosal as a preservative; the unit dose syringe formulations do not. FluMist is available in packages of 10 prefilled single-use sprayers. It must be stored frozen and administered shortly after being thawed. Dosing consists of two sprays – one in each nostril. FluMist does not contain thimerosal.

Reference:

[1]Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *Morbidity and Mortality Weekly Report*. May 28, 2004; 53 (No. RR06). Internet: http://www.cdc.gov/mmwr/PDF/RR/RR5306.pdf

BCBSNC Adds Hospital Comparison Tool to Support Consumer Decisions

Understanding their health care options can seem overwhelming for patients already making complicated medical decisions for themselves or their family members. We believe that the more members know, the easier it is for them to partner with their health care provider when selecting a hospital facility to best suit their health care needs and those of their family members.

As part of our commitment to provide members with new resources to assist them in making health care decisions, BCBSNC is offering the new Web-based Hospital Comparison Tool. By using the interactive tool to research facility resources, your patients requiring hospital-based care will be prepared to partner with you to make informed health care decisions. The newest addition to BCBSNC's suite of decision support tools, the Hospital Comparison Tool, allows members to select the features most important to them in choosing a facility – from driving distance to the number of patients treated to accreditation status.

Members can research hospitals anywhere in the United States to learn whether they have specialty care units, such as neonatal intensive care or cardiac intensive care. Side-by-side comparisons allow members to research a specific condition, such as heart surgery, cancer surgery or knee replacements – and even learn the complication rates for those procedures.

Many BCBSNC network hospitals have already previewed their information online, even adding helpful information about their facilities. Hospitals that have completed a Web survey as part of the Leapfrog initiative can share their performance with their communities. The Leapfrog initiative is focused on measuring hospital performance in regard to safety and quality issues.

You may already be familiar with BCBSNC's other decision support tools available at ***bcbsnc.com***:

PharmaAdvisor™

This online tool allows members to compare drug options and the costs of those options for treating specific medical conditions.

Health Line Blue℠

Health Line Blue provides BCBSNC members with evidence-based medical information via the phone or Web 24-hours a day, seven days a week. Nurses and Internet tools assist members in addressing symptom, diagnosis and care choice questions related to their health care.

Health Care Cost Estimator℠1

Members can use this online tool to research the relative cost (billed charges) of treatment options for specific inpatient conditions, outpatient procedures, and doctor's office visits and services.

BCBSNC decision support tools are not intended to replace the advice of a member's health care provider. They are designed to provide members with information to help them discuss options with their provider and to support them in making informed health care decisions.

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How to Avoid Claim Mailbacks

We continue to see a high number of claim mailbacks from providers. In an effort to help decrease the number of claim mailbacks, which will in turn improve turnaround time, we want to provide you with a list of the main reasons that claims are mailed back. Please review this information and ensure that your claims are complete and accurate before submitting them to BCBSNC. This will help to eliminate the mutual inconvenience of having claims mailed back to you for correction. The main reasons that claims are mailed back include:

- Invalid or missing BCBSNC individual or group provider number
- Invalid, incomplete or missing member ID (Please include the complete member ID including applicable prefixes and suffixes as they appear on the member's current ID card.)
- Invalid place-of-service code (filing one-digit code instead of a two-digit code)
- Missing or incorrect number of units
- Missing patient's date of birth
- Missing onset date of symptoms
- Missing or incomplete specific diagnosis
- Missing primary payer's EOB if BCBSNC is secondary
- Missing admission and discharge dates for inpatient claims

If you do receive a claim mailback with your returned claim, **please do not provide the missing information on the mailback form**. Please correct the claim and resubmit it to BCBSNC.

News from EDI Services

Tired of Sending Paper Claims? Check Out RealMed Print Exchange

Many of you who submit electronic claims to BCBSNC and other commercial payers are already aware of the convenience of real-time claims submission through our relationship with RealMed Corporation. RealMed is now taking this universal EDI capability one step further by offering a new product, RealMed Print Exchange, to those providers who submit paper claims to BCBSNC. All your practice needs is a MS Windows-based practice management application with print functionality and an Internet service provider.

RealMed Print Exchange enables your workstation print function to perform electronic claims filing. In less time than it takes to print and fold paper claims, separate them by payer, and stuff and mail envelopes, Print Exchange can electronically submit your claims to all of your payers.

As soon as Print Exchange receives your claims, it sends a receipt confirmation to you that is accessible through the RealMed Web site. You can track the status of the claim to BCBSNC or other payers through RealMed's online claims status screen. The Print Exchange product is HIPAA-ready, so it allows providers who cannot currently generate HIPAA-compliant electronic transactions to easily do so and benefit from the efficiency of electronic transaction processing.

For more information about how RealMed services can benefit your practice, contact your local BCBSNC EDI Services field consultant.

What Is Clear Claim Connection?

Clear Claim Connection, or C3, is a tool available to Blue ***e***℠ users that indicates the following information:

1) How combinations of procedure codes (including modifiers) will be bundled and/or unbundled for adjudication.

2) Whether or not the codes are in conflict with the age and gender information that has been entered for a claim. While C3 discloses most of the procedure code handling within BCBSNC lines of business, there are some additional edits that are not reflected by C3.

For more information on additional edits, see our reimbursement policy "Code Bundling Rules Not Addressed in ClaimCheck" in the Medical Policy section of ***bcbsnc.com***.

What C3 Is Not

C3 does not take into account many of the circumstances and factors that may affect adjudication and payment of a particular claim. For example, factors such as a member's benefits and eligibility or the medical necessity of the services performed, are not considered. Consequently, C3 cannot guarantee the payment of a claim. But C3 can take a lot of the guesswork out of understanding how your procedure codes will be handled by BCBSNC.

The "What's New" section of Blue ***e*** contains additional information about C3.

Blue *e* User Confidentiality

In order for us to maintain security regulations, please remember that you should not share your Blue ***e*** user ID, password or any other shared confidential information with anyone. If you have staff that needs access to Blue ***e***, they can be easily added to your user list. Simply download the "Blue ***e*** Additional Users Request Form" from the EDI Services section of the Provider home page at ***bcbsnc.com***. List their names and fax the form to EDI Services at **919-765-7101**. You can also use this form to inform us when staff members have left employment or no longer need access to the system. If you have a problem downloading the Additional Users Request Form or if you have questions about adding or deleting Blue ***e*** User IDs, please contact EDI Customer Support at **1-888-333-8594**.

EDI Services Information Sessions

EDI Services will be hosting information sessions this fall at cities across the state. Topics for discussion will include:

- Determining which electronic solution (RealMed, Blue ***e*** or HIPAA batch) is right for you
- New reporting tool for 835 remittances
- Update on implementing claim level rejection within 837 batch transmissions
- Overview of the Social Security number replacement project
- NPI numbers for all providers

The sessions will be held on the following dates in these cities:

October 12, 2004 - Winston-Salem

October 13, 2004 - Charlotte

October 14, 2004 - Durham

October 19, 2004 - Greenville

October 20, 2004 - Fayetteville

October 21, 2004 - Wilmington

October 26, 2004 - Asheville

October 27, 2004 - Hickory

Detailed information will be available on the "What's New" page on Blue ***e*** and the "Upcoming Events" page in

News from EDI Services (continued from page 4)

the EDI Services section of the Provider home page at ***bcbsnc.com***. Online registration for this event will also be available through ***Cvent.com.***

HIPAA Migration Status: Tips for Transitions to HIPAA Formats

EDI Services would like to offer the following suggestions to help you make a smooth transition to HIPAA compliance. Several critical points should be addressed with your software vendor or clearinghouse, particularly if you submit 837 claims. Here are questions that need to be asked now:

- Is my practice management/accounting system creating compliant 837 claims?
- What editing is performed prior to submission of claims to prevent batch failure?
- What reports will I receive to inform me that claims have been rejected prior to processing?
- How quickly will the practice be notified when claims have been rejected?
- Will I receive the BCBSNC Claims Audit Report?
- Do you validate the CPT, ICD-9 and HCPCS codes against the date of service?
- Are you submitting paper claims to BCBSNC on my behalf? If so, why?

As a reminder, here are the requirements for EDI submissions to BCBSNC:

- A completed Electronic Connectivity Request Form submitted to EDI Services.
- If you submit claims directly to BCBSNC and do not use a billing service or clearinghouse, then you will need to:
  - Submit a signed, original BCBSNC Trading Partner Agreement.
  - If your vendor has not tested previously, a successfully completed test from the BCBSNC/Communedi Web site is available for testing purposes at ***bcbsnc.communedi.com***.

BCBSNC Participating Labs

Participating network physicians have contractually agreed that when the need arises for a BCBSNC patient to receive other professional services – such as reference laboratory services – they will refer our members to other participating network providers. To confirm that a lab is participating, please contact BCBSNC Customer Services for the most up-to-date information. The following laboratories are participating in all BCBSNC products as of June 30, 2004:

- Alfigen, Inc.
- Ameripath Consulting Pathology Services
- Carolina Imaging and Diagnostics, LLC
- Carolina Medical Lab Group, Inc.
- Carolinas Medical Center Lab
- Clinical Data, Inc.
- Clinical Laboratory Services
- Coastal Carolina Pathology, PA
- Dianon Systems
- Fullerton Genetics Center
- Michael Friedberg, MD
- GeneCare
- Genzyme Genetics
- H P R H Reference Lab
- Harris Histology Relief Service
- Lab Corp. of America
- Liposcience, Inc.
- Macon County Health Department Lab
- Matria Laboratories, Inc.
- Meridian Laboratory Corporation
- Mission St. Joseph's Reference Lab
- Piedmont Pathology Associates
- Presbyterian Laboratory Services
- Quest FKA SBCL
- Rex Laboratory Outreach
- Sciteck Clinical Laboratories, Inc.
- Select Diagnostics, Inc.
- Skin Pathology Associates, PC
- Spectrum Laboratory Network
- Spruce Pine Reference Lab
- Triad Clinical Laboratory
- US Labs
- Wilkesboro Clinical Lab

If you are currently using the services of a nonparticipating reference laboratory, please encourage them to contact BCBSNC for more information about becoming a contracting provider in our networks. Reference labs that would like to participate in our networks can complete an application, which can be downloaded at ***bcbsnc.com***.

Medical Record Standards for Managed Care Primary Care Physicians and OB/GYN Physicians Providing Primary Care

In conjunction with our Physician Advisory Group and based on NCQA requirements, medical record standards were developed to encourage the quality and appropriateness of physician documentation in office medical records. It is against these standards that medical record reviews are conducted every three years on selected physicians. Standard # 24 dealing with the review of chronic medications is new for 2004.

Standard	Supporting Documentation
1. All pages contain patient identification.	1. Each page in the medical record must contain the patient's name or ID number.
2. Each record contains biographical/ personal data.	2. Biographical/personal data is noted in the medical record. This includes the patient's address, employer, home and work telephone numbers, date of birth and marital status. This data should be updated periodically.
3. The provider is identified on each entry.	3. Each entry in the medical record must contain author identification (signature or initials).
4. All entries are dated.	4. Each entry in the medical record must include the date (month, day and year).
5. The record is legible.	5. The medical record must be legible to someone other than the writer.
6. *There is a completed problem list.*	6. The flow sheet includes age appropriate preventive health services. A BLANK PROBLEM LIST OR FLOW SHEET DOES NOT MEET THIS STANDARD.
7. *Allergies and adverse reactions to medications are prominently displayed.*	7. Medication allergies and adverse reactions are PROMINENTLY noted in a CONSISTENT place in each medical record. If significant, allergies to food and/or substances may also be included. Absence of allergies must also be noted. Use NKA (no known allergy) or NKDA (no known drug allergy) to signify this. It is best to date all allergy notations and update the information at least yearly.
8. *The record contains an appropriate past medical history.*	8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (ages 18 and younger) past medical history relates to prenatal care, birth, operations and childhood illnesses. The medical history should be updated periodically.

Medical Record Standards (continued from page 6)

Standard	Supporting Documentation
9. Documentation of smoking habits and alcohol use or substance abuse is noted in the record.	9. The medical record should reflect the use of or abstention from smoking (cigarettes, cigars, pipes, smokeless tobacco), alcohol (beer, wine, liquor), and substance abuse (prescription, over-the-counter and street drugs) for all patients ages 14 and above who have been seen three or more times. It is best to include the amount, frequency, and type in use notations.
10. The record includes a history and physical exam for presenting complaints.	10. The history and physical documents appropriate subjective and objective information for presenting complaints.
11. Lab and other diagnostic studies are ordered as appropriate.	11. Lab and other diagnostic studies are ordered as appropriate for presenting complaints, current diagnosis, preventive care, and follow-up care for chronic conditions. It is best to note if the patient refuses to have recommended lab or other studies performed.
12. *The working diagnoses are consistent with the diagnostic findings.*	12. The working diagnosis is consistent with the findings from the physical examination and the diagnostic studies.
13. *Plans of action/treatments are consistent with the diagnosis(es).*	13. Treatment plans are consistent with the diagnosis.
14. Each encounter includes a date for a return visit or other follow-up plan.	14. Each encounter has a notation in the medical record concerning follow-up care, calls or return visits. The specific time should be noted in days, weeks, months or PRN (as needed).
15. Problems from previous visits are addressed.	15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. Appropriate use of consultant services is documented.	16. Documentation in the record supports the appropriateness and necessity of consultant services for the presenting symptoms and/or diagnosis.
17. Continuity and coordination of care between primary and specialty physicians or agency documented.	17. If a consult has been requested and approved, there should be a consultation note in the medical record from the provider (including consulting specialist, SNF, home infusion therapy provider, etc.)
18. Consultant summaries, lab and imaging study results reflect review by the primary care physician.	18. The primary care physician initials consultation, lab, and X-ray reports filed in the medical record or some other electronic method is used to signify review. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
19. *Care is demonstrated to be medically appropriate.*	19. Medical record documentation verifies that the patient was not placed at inappropriate risk as a result of a diagnostic or therapeutic process.

Medical Record Standards (continued from page 7)

Standard	Supporting Documentation
20. A complete immunization record is included in the chart.	20. Pediatric medical records contain a completed immunization record or a notation that "immunizations are up-to-date."
21. Appropriate use of preventive services is documented.	21. There is evidence in the medical record that age-appropriate preventive screening and services are offered in accordance with the organization's practice guidelines. (Refer to the Medical Policy section of your provider manual.) It is best to note if patient refuses recommended screenings and/or services.
22. Charts are maintained in an organized format.	22. There is a record-keeping system in place that ensures all charts are maintained in an organized and uniform manner. All information related to the patient is filed in the appropriate place in the chart.
23. There is an adequate tracking method in place to insure retrievability of every medical record.	23. Each medical record required for patient visit or requested for review should be readily available.
24. Review of chronic medications if appropriate for the presenting symptoms.	24. There is documentation in the record, either through the use of a medication sheet or in the progress notes, that medications have been discussed as appropriate.

Help Patients Save By Using the Clinical Rx Formulary

BCBSNC's clinical formulary is designed to assist you in maintaining quality of care while minimizing your patients' out-of-pocket expenses. Updated versions will be mailed to network physicians and pharmacies in October. The formulary provides information regarding both two-tier and three-tier prescription benefit plans.

In addition, the 2004 formulary includes the average prescription ingredient costs of listed drugs. Ingredient cost information comes from BCBSNC prescription claims and, as these costs are averages for each drug, they may vary depending on prescribed drug strength, dosage form and quantity. Drug cost information contained in these printed booklets was current as of summer 2004 and is not a guarantee of price.

We hope that you find this information helpful in the selection of safe, effective and economical prescription drugs for your patients. We also encourage you to select generic medications when they are available and appropriate, as these drugs represent effective treatment options and will, in most cases, cost significantly less for the patient.

For members enrolled in Blue Care®, Blue Choice® and Blue Options℠, certain drugs may require prior Plan approval or be subject to quantity limitations. Drugs subject to prior Plan approval and/or quantity limits are noted in the formulary. You can also access the most current version of BCBSNC's formulary, including average drug costs, on our Web site at **bcbsnc.com**.

Facility Standards for Managed Care Practices

The following standards for the facilities of practices participating in our managed care programs have been adopted by Blue Cross and Blue Shield of North Carolina and are endorsed by the Physician Advisory Group for use in assessing the environment in which health care is provided to our members.

Additional standards that deal with patient safety and the practice's ability to render emergency care if necessary have been added for 2004. Standards #11 and #12 have been identified as critical elements. Failure to comply with either of these standards could result in a shortened credentialing cycle or possible removal from the network.

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 adequat 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. A fire extinguisher is clearly visible and is readily available.

4b. 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.
    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 that 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 network.

Claim Filing Reminders for IV Therapy and Home Health Service Providers

In an effort to process claims more efficiently, the BCBSNC Medical Review Claims Department asks that IV therapy and home health providers follow these guidelines when submitting claims:

1. If you are an IV therapy provider and will also be providing skilled nursing services from your own company, be sure to include the "99601" CPT code when billing for the nursing services. This is in addition to the per diem "S" codes and the appropriate drug codes.
2. If you are an IV therapy provider and are subcontracting out the skilled nursing services, please make a note of that when you send in your claims. This can be written on a separate line of the HCFA as "nursing-subcontracted." Notifying us that the skilled nursing part of the member's care is being subcontracted is extremely helpful when reviewing claims. Continue to include the CPT code 99601 so that payment can be made to your office.
3. If you are a home health agency and are the sole provider of care, please make a note of that when you send in your initial claims. This can be written on a separate line of the HCFA as "nursing-subcontracted."
4. If you are a home health agency and are the subcontractor for an IV therapy company, you should not be submitting claims. This results in incorrect payments and confusion about who's providing what service.

Changes to Licensed Ambulatory Surgery Center Claims Filing Process

BCBSNC has updated its reimbursement policy for multiple surgical procedures to clarify how the "primary procedure" is defined as well as how modifier 50 (used for bilateral procedures) must be billed. These revisions impact members covered under all BCBSNC HMO, POS, PPO and CMM products.

For all claims received on or after July 15, 2004, from facilities licensed as ambulatory surgery facilities by the state of North Carolina, the first line on the claim will be designated as the primary procedure and will be processed at 100 percent of the allowable charge. The primary procedure CPT code shall be listed on the UB92 in form locator field #44.

The eligible secondary procedures will continue to be processed at 50 percent of the allowable charges. In addition, for bilateral procedures, BCBSNC will accept modifier-50 in conjunction with CPT codes on the UB92 claim form in form locator #44. Form locator #44 may have a separate line for each CPT code with one unit in form locator #46, or a single line CPT code in form locator #44 with two units reflected in form locator #46. RT and LT modifiers may be used when applicable.

For more information on BCBSNC's administrative policies, please contact your local Network Management field office.

Last "Open Window" in 2004 for FEP Claims

"Open Window" is a period of time when the Federal Employee Plan (FEP) can process claims with services incurred more than two calendar years prior to the current year. It's important to note that FEP policy limits the payment of timely filed claims to specific conditions. You can contact FEP Customer Service at **1-800-222-4739** for specific condition information.

We must have claims three weeks prior (in house by November 15, 2004) to the "Open Window" dates of December 6-17, 2004, in order for the claims to be eligible for this special consideration.

Help Prevent Kidney Disease

Kidney disease is a public health problem affecting roughly 20 million American adults. The spectrum of chronic kidney disease (CKD) includes five stages of disease, beginning with individuals with mild kidney damage and progressing to those with kidney failure. Prevention is possible, and early identification may slow the progression towards kidney failure and reduce cardiovascular risks.

How Is Kidney Disease Detected?

The National Kidney Foundation (NKF) recommends three simple tests to check for kidney disease:

- Blood pressure measurement
- Urinalysis to check for protein
- Serum creatinine level
- Estimate glomerular filtration rate (GFR) from serum creatinine using the Modification of Diet in Renal Disease Study Group (MDRD) equation, available at ***kdoqi.org***.

Who Should Be Tested?

The NKF suggests that screening be done on adults with:

- Diabetes (once per year)
- Hypertension at diagnosis and initiation of therapy
- A family history of kidney failure

What Causes Chronic Kidney Disease?

The two main causes of CKD and kidney failure are diabetes and high blood pressure. When left uncontrolled or poorly controlled, hypertension can be the leading cause of heart attacks and strokes. Persons with CKD should be considered in the highest risk group for cardiovascular disease. Kidney disease may also result from prolonged consumption of some over-the-counter painkillers that combine aspirin, acetaminophen and other medicines such as ibuprofen or NSAIDS.

Assistance in Managing CKD Patients

Blue Cross and Blue Shield of North Carolina is pleased to offer *Your Renal Care*[SM1] to assist you in identifying and supporting people with Stage IV CKD and ESRD. To do this, BCBSNC has partnered with Renaissance Health Care, a renal disease management company, which assists members with kidney disease.

The goal of *Your Renal Care* is to coordinate the efforts of the patient's health care team through individualized care management. This strategy incorporates interventions designed to protect existing kidney function, prevent or attenuate co-morbid conditions, address anemia and metabolic bone disease, and prepare patients for kidney function therapy so that it can be initiated as efficiently as possible. In order to promote coordination with care managers and health care providers, patient care summaries are shared with providers periodically. To find out if your patients qualify for the CKD or ESRD programs, or to receive additional information on the program, please contact the *Your Renal Care* program manager, Audrey Hogan, at **1-800-218-5295, extension 1585.**

What Can Primary Care Providers Do?

The NIH National Kidney Disease Education Program recommends that you:

- Recognize who is at risk.
- Promote testing and treatment.
- Encourage labs to provide and report estimated GFR and spot urine albumin/creatinine ratios.
- Use GFR as an indicator of kidney damage.
- Help patients maintain blood pressure less than 130/80 mmHg.
- Encourage patients to consult a nephrologist early.

Where to Find More Information

Chronic Kidney Disease Clinical Practice Guidelines from the National Kidney Foundation are available online at the K/DOQI Web site at ***www.kdoqi.org***. The National Kidney Disease Education Program through the National Institutes of Health provides free resources for health professionals at ***www.nkdep.nih.gov***.

The information provided in this article is adapted from materials provided by the NKDEP, the National Kidney Foundation and Renaissance Health Care, Inc.

Drug Additions to Prior Approval List

Effective August 30, 2004, BCBSNC expanded the requirements for a drug that requires prior approval and added a new drug to our prior approval list.

Recently, the United States Food and Drug Administration expanded the use of Enbrel to include treatment for psoriasis. Enbrel is already on the prior approval list for the treatment of rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis. As a result of the FDA's approval for expanded use, treatment with Enbrel will also require prior approval for use in treating psoriasis.

In addition, Raptiva, which was also recently approved by the FDA for the treatment of psoriasis, was added to the prior approval list effective August 30.

BCBSNC Pilots Stress Management Program

This spring, Blue Cross and Blue Shield of North Carolina launched a pilot program to help our members cope better with stress. The Managing Stress Program will target about 3,000 members this year. Members will be identified through their claims history and will come from three key groups:

- Members who recently survived a heart attack.
- Pregnant women at elevated risk for postpartum depression (either due to a personal history of depression or high depressive symptomatology in mid-pregnancy).
- Depressed members starting a new course of antidepressant therapy.

As part of the program, members will receive:

- A brochure on stress management.
- Educational materials on lifestyle choices around nutrition and exercise.
- Information on the signs of depression, how to access behavioral health care, and the importance of treatment adherence for prevention of relapse and recurrence.

In addition, BCBSNC members will be able to select one of the following:

- A CD with relaxation techniques narrated by Dr. Stuart McCalley, a physician at Yale University, and a workbook of cognitive restructuring exercises.
- A pedometer to encourage regular physical exercise.
- The book *Food and Mood* by registered dietitian Elizabeth Somer.
- The mPower Wellness Workshop on CD-ROM, developed with a grant from the National Institute of Mental Health and clinically shown to reduce symptoms of depression and anxiety.

All materials have undergone clinical review by BCBSNC medical directors, various behavioral health practitioners on the Magellan Behavioral Health Quality Improvement Committee, and the BCBSNC Provider Advisory Group. If you have questions about the Managing Stress Program, please contact Susan Pfannenschmidt, BCBSNC Quality Improvement at **1-919-765-4798** or via e-mail at *Susan.Pfannenschmidt@bcbsnc.com*.

Protecting Your Patients' Health Care Needs

Did you know that there are standards in place that protect your patient, the health care consumer? The National Committee for Quality Assurance (NCQA), a not-for-profit organization that accredits Blue Cross and Blue Shield of North Carolina, has developed standards that do just that. BCBSNC wants you to know that:

- Any decisions made about coverage for care or services are based on your patient's benefit plan, BCBSNC medical policy, and information from the doctor about the patient's medical condition.
- The BCBSNC doctors and nurses that review your and your patient's requests for service or coverage are not rewarded for denying coverage.
- The BCBSNC doctors and nurses that review your and your patient's requests for service or coverage are not given bonuses or other financial incentives to deny or limit care.

At BCBSNC, we are committed to making appropriate coverage decisions about health care that meet the terms of your patients' health benefit plan, while meeting their medical needs.

Revision to BCBSNC Multiple Surgical Procedure Guidelines

BCBSNC recently notified physicians of revisions to its reimbursement policy for multiple surgical procedures. Our goal was to clarify how we define a "primary procedure."

For professional claims received on or after August 1, 2004, the primary procedure will be based on the CPT code assigned the highest relative-value unit as defined by the most current version of Claim Check, which is utilized by BCBSNC. This differs from our existing practice of defining the primary procedure based on the highest charge. BCBSNC will continue to reimburse the primary procedure at 100 percent of the allowable charge or the fee schedule allowance – whichever is less.

Allowance for each secondary procedure will remain at 50 percent when the specific criteria in BCBSNC's multiple surgical procedure medical policy are met. This change affects only those patients who are covered by Blue Care, Blue Choice, Blue Options, Classic Blue® and Blue Advantage (i.e., Blue Advantage members in the Blue Options network who can be identified by the alpha prefix "YPP" on their ID card). Please note that this policy change does not apply to our CMM products.

BCBSNC is making this revision to better align reimbursement and payment logic for claims adjudication for the above products. For more information on BCBSNC's administrative policies, please contact your local Network Management field office or go online to ***bcbsnc.com***.

Blue Link Reminders and Updates

Clarification re COB Process in the 2004-2005 *Blue Book*

Section 11.5, "BCBSNC Secondary to Other Commercial Insurance Primary Payment," of the 2004-2005 physician *Blue Book*, states that claims will be suspended if there is a question about possible secondary coverage. However, if we receive a claim for which BCBSNC is secondary, the claim will be denied pending receipt of the primary insurer's Explanation of Payment/Benefits. Please make note of this distinction in your current copy of the *Blue Book*. The PDF version has been updated with this information if you would like to download it from Blue ***e***.

Attention Greenville Area Providers

Please note that our Wilmington office is now handling all BCBSNC Network Management calls for the Greenville area. The toll-free number is **1-877-889-0001**.

Farm Bureau Product to Be Discontinued

BCBSNC is discontinuing the North Carolina Farm Bureau Health Program, effective January 1, 2005. The product will no longer be offered due to rising medical costs, which have lead to significant rate increases, and a steady decline in Farm Bureau membership over the last few years. We expect the majority of Farm Bureau members to move to our Blue Advantage product, which will be offered to them as a guaranteed coverage option.

New Rates for DME Home Items

Please refer to your contract for more information about the new rates that went into effect on August 1, 2004, for home durable medical equipment.

Medical Records

Please do not send medical records unless requested by BCBSNC. We will send you a medical record request form that needs to be completed and returned with the records requested.

We Have a Winner!

Well, actually we have two winners! Congratulations to Dana Johnson of Forsyth Home Care in Winston-Salem and to Linda Swett of Cabarrus Family Medicine who each won a $50 American Express gift cheque for participating in the BCBSNC annual provider satisfaction survey. If you haven't completed a survey yet, you may do so online at ***bcbsnc.com*** via the "I'm a Provider" home page. Just click on "Provider Survey" and respond today for your chance to win. BCBSNC will also donate $1 for each response to Be Active North Carolina.

BlueCard® Updates

BlueCard Claims Inquiry

Did you know that you can now check BlueCard claims status on Blue ***e***? Just enter the exact ID number, including the alpha characters. You can inquire about ID numbers that have the alpha characters in a position other than as a prefix or those ID numbers with less or greater than nine characters following the prefix.

Benefit Changes for CVS Corporation Employees

Beginning in June, Blue Cross and Blue Shield of Rhode Island began offering both a PPO and an EPO plan option for CVS employees in North Carolina whose claims are processed through the BlueCard program. The member ID card for these employees will be issued by BCBSRI and will contain the alpha prefix "KCB" along with the "PPO suitcase" logo for the PPO product and a "blank suitcase" for the EPO product. Applicable copayments and deductibles will be listed on the ID card.

Vision and Hearing Claims

Please note that vision and hearing claims should be submitted through the BlueCard program when warranted. We suggest that you make this correction to section 6/2 of your current copy of the physician *Blue Book*.

Tips for Electronic Filing of Medicare COB Information

Please note the following steps when filing a UB92 claim with Medicare-primary COB information. This process is only for BlueCard Host COB hospital claims filed electronically via 837:

- The Medicare allowed amount should be filed using an AMT segment in the 2320 loop with a "B6" qualifier and the corresponding dollar amount.
- The Medicare paid amount should be filed using an AMT segment in the 2320 loop with a "C4" qualifier and the corresponding dollar amount.
- The contractual adjustment should be filed using the CAS Segment in the 2320 loop using a claim adjustment group code of "CO", claim adjustment reason code "45" and the corresponding claim adjustment dollar amount.
- The claim level deductible amounts should be filed using the CAS Segment in the 2320 loop using a claim adjustment group code of "PR", claim adjustment reason code "1" and the corresponding claim adjustment dollar amount.
- The claim level coinsurance amounts should be filed using the CAS Segment in the 2320 loop using a claim adjustment group code of "PR", claim adjustment reason code "2" and the corresponding claim adjustment dollar amount.

Please do not use the value codes of A1 and or A2 on the 837 for deductible and coinsurance when filing an 837 institutional BlueCard claim. Please use the CAS Code Segments as indicated above.

Correct Submission of BlueCard Claims

To expedite claims processing for all BlueCard claims, you must submit the member's ID number as it is listed on the ID card. Always include the member's prefix along with the ID number. Adding any additional information will hinder the processing of the claim. Please follow these helpful hints:

- The member ID will always include the alpha prefix in the first three or more positions.
- Following the alpha prefix, the ID card may include any combination of alpha or numeric characters for a maximum length of 17 characters total (*3-character alpha prefix and up to 14 alpha/numeric characters*). You may see cards with ID numbers that are fewer than 17 characters in total. **Remember that member ID numbers must not be changed or altered.**
- Always make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- To ensure that the member gives you the most current ID card, please request the card at every visit.

Whether the most current ID card contains the Social Security number or an alternate unique identification number, please enter the identification number ***exactly*** as it appears on the member's card, including the alpha prefix, and pass this key information to your billing staff.

What Would You Like to Know About BlueCard?

We heard from many of you who completed our recent *Blue Link* survey that you want more information about BlueCard. We want to provide you with the information you need, but it would help us to know if there are specific aspects of BlueCard that you would like to know more about. Please e-mail Susan Lovett, editor of *Blue Link*, at *Susan.Lovett@bcbsnc.com* with the specific BlueCard topics you would like to see us cover in future issues.

State Health Plan Briefs

Allowable Charge Changes for Laboratory Service Codes

Effective October 1, 2004, the State Health Plan, including NC Health Choice for Children, will be updating the customary allowable amount and UCR for approximately 100 laboratory service codes. The Plan is targeting codes that are currently being reimbursed at nearly twice the amount of Medicare rates. It is the Plan's intention to bring these more utilized laboratory codes in line with market rates. By updating the customary allowable amount for these codes, we will ensure that all providers are equitably reimbursed. Providers were sent a letter and list of affected laboratory codes in July. If you have any questions, please contact the State Health Benefits Office at **1-919-881-2300**.

Elimination of the 90-Day Grace Period for Discontinued ICD-9-CM Codes

Effective for dates of service on and after October 1, 2004, no further 90-day grace periods will apply for the annual ICD-9-CM updates. Providers must bill using the diagnosis code that is valid for the date of service. Claims filed with discontinued codes will be mailed back.

Certified Registered Nurse Anesthetist

We continue to receive a lot of calls about CRNA benefits under the State Health Plan. Professional fees for a hospital or facility-employed anesthesiologist or certified nurse anesthetist, when billed separately, are not covered except when Medicare is the primary carrier. The administration of anesthesia by the hospital or facility-employed CRNA is considered a part of the anesthesia services and is covered under the hospital DRG reimbursement. Professional fees for services of a CRNA employed by the anesthesiology practice are not covered separately.

Medical Review and Medical Records

When submitting medical records, we must have the member's ID number and the provider's phone and fax numbers. If we receive incomplete medical records, a Medical Records Request form will be mailed to the provider to obtain the additional records. To ensure that the processing of the claim is not delayed, please send only the requested information. Providers will be notified of approvals and denials via fax. In the absence of a fax number, a phone call is placed to the provider. Prior approval forms can be obtained from the State Health Plan's medical policy Web site at ***nc-shp.com***. Please note that prior approval forms are not a substitute for medical records specific to a patient's medical condition.

How to File Newborn Baby Claims

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

To correctly file a claim for a newborn baby, the provider should put the newborn's name and date of birth on the claim and 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 under the mother's name on your Notification of Payment.

Preadmission certification (PAC) is required if the mother's hospital stay is longer than 48 hours for vaginal delivery or 96 hours for cesarean section. PAC is also required when the newborn requires special care.

Coordination of Benefits

We continue to receive unsolicited refunds on secondary claims because the primary payer has not clearly indicated a write-off or discounted amount. When filing secondary claims, document on the Explanation of Benefits or claim *(note: for State Health Plan only – not for BCBSNC claims)* any write-off amount or discounts that the patient is not responsible for, as this will help us coordinate the claim correctly on the first submission. Do not use the other carrier field on the UB-92 or the HCFA 1500 unless the patient has other insurance. Data placed in these fields when the patient does not have other coverage delays processing.

Why Are My State Health Plan Claims Being Mailed Back?

Listed below are the top reasons that we have to mail back State Health Plan claims. Please review this list to ensure that your claims are complete and accurate on the first submission.

- BCBSNC provider number missing or invalid
- Incomplete or missing member ID number
- No onset date for injury and/or poisoning diagnosis codes: ICD9 codes (800-999)
- Invalid place-of-service code (filing one-digit instead of two-digit code)
- Units missing or incorrect
- Patients date of birth missing
- Invalid procedure codes and diagnosis codes
- Admission and discharge dates missing for inpatient professional services

State Health Plan Briefs (continued from page 14)

- To and from dates not filed for monthly durable medical equipment rental
- Missing primary payer's Explanation of Benefits when the State Health Plan is secondary

Please note that if you do receive a mailback with your returned claim, please do not write the missing information on the mailback form. The information should be corrected on the claim and the claim resubmitted.

New Claim vs. Corrected Claim

We receive a large volume of claims stamped "corrected claim" that are actually new claims. A corrected claim should only be submitted for a claim that has been previously paid or denied as indicated on your Notification of Payment. If we mail a claim back to you requesting missing or incomplete information, you should not stamp "corrected claim" on it when you resubmit it. In fact, doing so could delay processing because the claim has to start the claim life cycle all over again. When submitting a true corrected claim, please stamp or write "corrected claim" on an area of the claim so that it is clearly visible.

State Health Plan Claims Filing Address

State Health Plan claims should be mailed to:

State Health Plan
P.O. Box 30111
Durham, NC 27702-3025

Please remember that State Health Plan claims and Blue Cross and Blue Shield of North Carolina claims should never be mailed in the same envelope as this could delay or prevent claims from being processed in a timely manner.

Top Five Things to Avoid When Filing Claims or EOBs

We realize that there may be items on a claim or Explanation of Benefits (EOB) that you want to call to our attention, but it's important to remember that our optical claims scanner sees a highlighted area as nothing more than a dark, illegible area on the document. As a reminder, here are the top five things you need to avoid doing to a claim or EOB that you are submitting to BCBSNC:

- Do not highlight any information on the claim or EOB.
- Do not handwrite any additional information on the claim or EOB.
- Do not staple claims or EOBs together.
- Do not use paperclips.
- Do not fold the claim or EOB.

BCBSNC will mail back claims and EOBs that are filed incorrectly and cannot be scanned. Be sure to match the patient information listed on the claim with the EOB that you are submitting and limit the EOB information you are sending to us to just the patient in question.

How Are UM Decisions Made?

Licensed nurses and physicians using established criteria – the Milliman Care Guidelines and BCBSNC Corporate Medical Policy – make all medical necessity determinations at BCBSNC. The Milliman Care Guidelines are used to authorize coverage for inpatient services and for length-of-stay extensions, as well as for home care and rehabilitation services. BCBSNC Corporate Medical Policy is applied to services on the BCBSNC prior Plan approval list.

You can obtain a copy of a Milliman Care Guideline for a specific member and/or diagnosis or procedure or a specific medical policy by calling the BCBSNC Medical Resource Management Department at **1-800-672-7897, ext. 57078**. Our medical policies are also available for your reference online at ***bcbsnc.com***.

If a nurse cannot approve a service, a BCBSNC medical director will review the case and may approve or deny coverage based on the Milliman Care Guidelines or corporate medical policy, along with clinical judgment. ONLY a medical director can deny coverage for a service based on medical necessity. We encourage you to take advantage of the offer of a "peer-to-peer" consultation regarding a case before or after a determination, because a discussion between physicians can help clarify a situation and may affect the determination. A BCBSNC medical director can be reached by calling **1-800-672-7897, ext. 51019**.

Drug Costs Available in New Formulary Books and Online

The new 2004 member formulary booklet and clinical formulary book for providers will include average prescription prices this year. This is a change from the relative cost indicators that have been included in past formulary books. Average drug cost information is being provided to assist you in choosing the most economically feasible drug therapy for your patients.

Prescribing cost-effective drugs helps to ensure that a prescription drug benefit remains affordable for patients. In addition, while most BCBSNC members pay a fixed copayment for a medication according to which tier it has been placed in, others may have coinsurance and deductibles apply to their payment. We hope you find this information useful in helping your patients lower their out-of-pocket payments.

Generic Drugs = Savings for Members

We encourage you to select generic medications when they are available, as these drugs represent effective treatment options and will, in most cases, cost significantly less to your patients.

The drug costs listed in the formulary are average prescription ingredient costs, according to BCBSNC's claims data. As these costs are averages for each drug, they may vary depending on prescribed drug strength, dosage form, and quantity. Please note that the drug cost information contained in these booklets was current as of summer 2004 and is not a guarantee of price. For more current drug pricing information, you and your patients may search for a drug online using our Prescription Drug Search at ***bcbsnc.com***.

Member formulary booklets will be sent to members this fall via the BCBSNC health and wellness magazine, *Active Blue*. You should receive your clinical formulary books in mid-to-late October.

Snort, Sniffle, Sneeze. No Antibiotics Please!

The Centers for Disease Control and Prevention (CDC) continues to use their successful promotional campaign entitled "Get Smart: Know when Antibiotics Work" to help improve consumer knowledge of antibiotic resistance and the appropriate use of antibiotics. The Get Smart antibiotic information can be found at ***cdc.gov/getsmart/***.

The site has many educational tools for patients and parents, including:

- Brochures, posters, "prescription" pads, and letters for daycare providers. These can be ordered from the CDC for a small fee, or downloaded from the Web site, copied and distributed free of charge.
- General information on antibiotic resistance and tips on how to prevent antibiotic-resistant infections.
- Frequently asked questions about the appropriate use of antibiotics in colds and flu, runny noses, and middle ear fluid.

Information for health professionals includes:

- Technical information such as treatment guidelines for upper respiratory infections.
- Recently published articles on appropriate antibiotic use in the community.
- Links to useful related sites within the CDC.

BCBSNC Offers Free Flu Shots for Members

Flu season is right around the corner, and this year BCBSNC is leading a multi-phased flu shot initiative with the goal of making sure that more North Carolinians than ever get vaccinated. And that includes free flu shots for all BCBSNC members. We want to make it more convenient for our members to receive flu shots. We're also assisting public health departments and free clinics in providing the vaccine to their patients.

Beginning Oct. 1, all BCBSNC members (including state and federal employees) will be able to receive a free flu shot at hundreds of retail pharmacies and grocery stores. All members have to do is present their member ID card and show a photo ID. These community flu shot events are open to members ages 9 and up. A parent must accompany members who are under 18, and pregnant women in their first trimester must have a physician's written prescription for the flu vaccine.

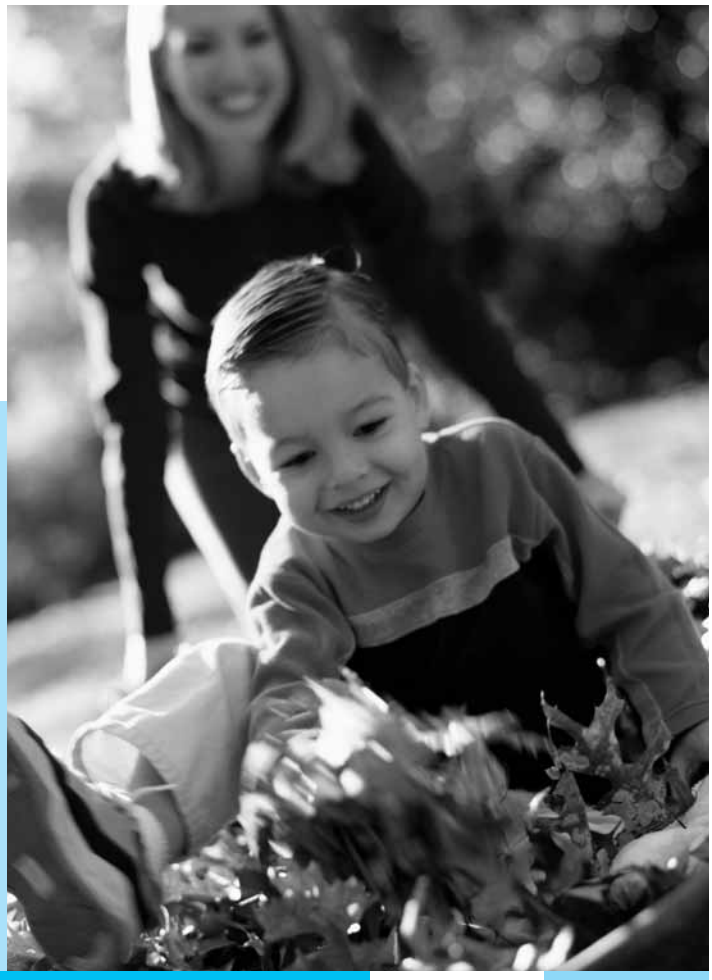
For this year only, BCBSNC is covering the cost of flu shots for all of our members. This is a pilot program designed to examine the effectiveness of offering flu shots as a way to minimize health care costs that may result when members contract the flu.

Members may still receive the flu shot from their physician, subject to the availability of the vaccine. In most cases, members with preventive health benefits as part of their policy will not be charged for receiving the flu shot from their physician. Some members may be charged an office visit copayment. Members should check their specific health plan's benefit booklet to see what conditions apply to them.

Flu Shots for the Uninsured

BCBSNC knows that North Carolinians without health insurance may find it especially difficult to get a flu shot. That's why we have made a financial grant to public health departments across the state so that they may purchase more flu vaccine. In addition, through an existing partnership of the BCBSNC Foundation with the North Carolina Association of Free Clinics, patients at those clinics will be able to receive a flu shot.

With this comprehensive and combined approach, BCBSNC hopes this winter will be flu-free for many North Carolinians.



Clinical practice guidelines help clarify care expectations and are developed based on evidence of successful practice protocols and treatment patterns. Clinical practice guidelines are used as a basis to evaluate care that could be reasonably expected under optimal circumstances. Preventive care guidelines provide screening, testing and service recommendations based upon national standards.

BCBSNC endorses the following nationally recognized practice and preventive care guidelines:

Nationally Accepted Guidelines

Asthma

Source: National Institutes of Health National Heart, Lung, and Blood Institute – Guidelines for the Diagnosis and Management of Asthma
Web site: *www.nhlbi.nih.gov/guidelines/asthma*

Diabetes

Source: American Diabetes Association: Clinical Practice Recommendations
Web site: *www.diabetes.org/for-health-professionals-and-scientists/cpr.jsp*

Heart Failure

Evaluation and Management
Source: ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult
Web site: *www.americanheart.org/presenter.jhtml?identifier=3000656*

Pharmacological Approaches
Source: HFSA Guidelines for Management of Patients With Heart Failure Caused by Left Ventricular Systolic Dysfunction – Pharmacological Approaches
Web site: *www.hfsa.org/hf_guidelines.asp*

Immunizations – Childhood and Adolescent

Source: Centers for Disease Control and Prevention 2004 Childhood and Adolescent Immunization Schedule
Web site: *http://www.cdc.gov/nip/recs/child-schedule.htm#Printable*

Immunizations – Adult

Source: Centers for Disease Control and Prevention 2004 Adult Immunization Schedule
Web site: *http://www.cdc.gov/nip/recs/adult-schedule.htm*

If you would like to receive a written copy of any of the guidelines listed above, please call **1-800-218-5295**. If you leave a message please indicate which guideline(s) you are requesting and spell out your name, practice name and mailing address. In addition, please leave a daytime phone number where we can reach you in case we have any questions.

Primary source: AAP/ACOG Guidelines for Perinatal Care, 5th Edition, 2002

Preconception Care*

Maternal Assessment

- Family history
- Genetic history (both maternal and paternal)
- Medical history
- Current medications (prescription and nonprescription)
- Substance use, including alcohol, tobacco and illicit drugs
- Domestic abuse or violence assessment
- Nutrition
- Environmental exposures
- Obstetric history
- General physical examination

Immunizations for Women at Risk

- Rubella (at least one month prior to conception or else hold until post-partum)
- Hepatitis B
- Varicella (at least one month prior to conception or else hold until post-partum)
- Influenza (and all women >13 weeks during flu season)

Screening / Testing

- Human immunodeficiency virus (HIV)
- Sexually transmissible infections, based on risk assessment (repeated at 32 to 36 weeks if risk factors persist)
- Test to assess recurrent pregnancy loss
- Test for maternal diseases based on medical or reproductive history
- Test for tuberculosis (e.g., Mantoux skin test with purified protein derivative)
- Test for genetic disorders based on racial and ethnic background such as:
  - Sickle hemoglobinopathies
  - β-thalassemia or α-thalassemia
  - Tay-Sachs disease
  - Cystic fibrosis (offer for high risk, but have information available to all) or family history such as:
  - Cystic fibrosis (offer for high risk, but have information available to all)
  - Mental retardation
  - Duchenne muscular dystrophy

* Women who do not seek preconception care should have these issues addressed as early in pregnancy care as possible.

Recommended Patient Education

Counseling

- Preventing and testing for HIV infection
- Determining the time of conception (i.e., by encouraging the patient to keep an accurate menstrual calendar)
- Abstaining from tobacco and alcohol use
- Consuming folic acid, at least 0.4 mg per day, while attempting pregnancy and during the first trimester for prevention of neural tube defects (NTDs)
- Maintaining good control of any preexisting medical conditions (e.g., diabetes, hypertension). Type I insulin dependent diabetic women should be encouraged to see an endocrinologist for optimal diabetic control prior to conception.
- Scope of care that is provided in the office
- Laboratory studies that may be performed
- Expected course of the pregnancy
- Signs and symptoms to be reported to the physician (e.g., bleeding or rupture of membranes)
- Anticipated schedule of visits
- Practices to promote health maintenance (e.g., use of safety belts)
- Educational programs and literature, including childbirth education classes
- Options for intrapartum care
- Planning for discharge and child care
- Nutrition, including ideal caloric intake and weight gain
- Exercise and daily activity
- Abstaining from tobacco, alcohol and drugs before and during pregnancy
- Explain the roles of the various members of the health care team, office policies (including emergency coverage), and alternate physician coverage.
- Role of the pediatrician
- Plans for hospital admission, labor, delivery and anesthesia services
- What to do when labor begins, when membranes rupture, or if bleeding occurs
- Consequences of ingesting solid food after the onset of labor
- Aspects of maternal postpartum care, including postpartum contraception and sterilization
- Infant feeding plans including contraindications of breastfeeding
- Available lactation support services
- Aspects of newborn care, such as cord care, physiologic jaundice, and circumcision of male neonates
- Timing of discharge from the hospital and any necessary preparations (i.e., obtaining a car seat)
- Resources available for home health services after discharge
- Education on stopping and resuming work
- Counseling and assistance when appropriate regarding: psychosocial services, adolescent pregnancy, domestic violence and substance abuse.

Early and Ongoing Pregnancy Risk Identification

(Patients with these risk factors should be managed by an obstetrician-gynecologist and/or a maternal-fetal medicine subspecialist)

Medical History/Conditions

Pre and Early Pregnancy

Asthma
- Symptomatic (on medication)
- Severe (multiple hospitalizations)

Cardiac disease
- Cyanotic, prior myocardial infarction, aortic stenosis, primary, pulmonary hypertension, Marfan syndrome, prosthetic valve, American Heart Association Class II or greater; other

Diabetes mellitus
Drug/alcohol use (including tobacco)
Epilepsy (on medication)
Family history of genetic problems (Down Syndrome, Tay-Sachs disease)
Hemoglobinopathy (SS, SC, S-thal)
Hypertension
- Chronic, with or without renal or heart disease

Previous Pap or GYN history
Prior pulmonary embolus/deep vein thrombosis
Psychiatric illness, especially risk for post partum depression
Pulmonary disease
- Severe obstructive or restrictive
- Moderate

Renal disease
- Chronic, creatinine ≥3 with or without hypertension
- Chronic, other

Requirement for prolonged anticoagulation
Severe systemic disease

Ongoing Pregnancy

Drug/alcohol use
Proteinuria (≥2+ by catheter sample, unexplained by UTI)
Pyelonephritis
Severe systemic disease that adversely affects pregnancy (such as Systemic Lupus Erythematosus)

Obstetric History/Conditions

Pre and Early Pregnancy

Age ≥35 at delivery
Cesarean delivery, prior classical or vertical incision
Incompetent cervix
LEEP or cone biopsy
Prior fetal structural or chromosomal abnormality
Prior neonatal or fetal death
Prior preterm delivery or premature rupture of membranes (PROM)
Prior low birth weight (<2,500 g)
Second-trimester pregnancy loss
Uterine leiomyomata or malformation

Ongoing Pregnancy

Blood pressure elevation (diastolic ≥ 90 mmHG or 20 point increase in diastolic blood pressure over baseline), no proteinuria
Fetal growth restriction suspected
Fetal abnormality suspected by ultrasound
- Anencephaly
- Other

Fetal demise
Gestational age of 41 weeks (to be seen by 42 weeks)
Gestational diabetes mellitus
Herpes, active lesions at 36 weeks
Hydramnios by ultrasound
Hyperemesis persisting beyond first trimester
Multiple gestation
Oligohydramnios by ultrasound
Preterm labor, threatened, at <37 weeks
PROM
Vaginal bleeding at ≥14 weeks

Laboratory tests/Examination

Pre and Early Pregnancy

HIV
- Symptomatic or low CD4 count
- Other

CDE (Rh) or other blood group isoimmunization (excluding ABO, Lewis)
Condylomata (extensive, covering labia/vaginal opening)

Ongoing Pregnancy

Abnormal MSAFP (low or high)
Abnormal Pap test
Anemia (Hct <28%, unresponsive to iron therapy)

Abbreviations: MSAFP = maternal serum alpha-fetoprotein; Hct = hematocrit; UTI = urinary tract infection

Antepartum Surveillance

Examinations

Schedule

(Appropriate for an uncomplicated pregnancy; women with medical or obstetrical problems, as well as younger adolescents, may require closer surveillance)

- Every 4 weeks for the first 28 to 30 weeks
- Every 2-3 weeks until 36 weeks
- Weekly after 36 weeks of gestation

Goals

- Establish an accurate estimated date of delivery
- Monitor the progression of the pregnancy
- Provide education and recommended screening and interventions
- Reassure the mother
- Assess the well-being of the fetus and mother
- Detect medical and psychosocial complications and institute indicated interventions

Assessment

- Blood pressure
- Weight
- Urine protein and glucose
- Uterine size for progressive growth and consistency with estimated date of delivery
- Fetal heart rate
- After the patient reports quickening, she should be asked about: fetal movement, contractions, leakage or fluid and vaginal bleeding

Routine Testing

- Hematocrit or hemoglobin
- Urinalysis, including microscopic examination
- Urine testing to detect asymptomatic bacteriuria
- Determination of blood groups and CDE (Rh) type
- Antibody screen
- Rubella virus immunity
- Group B Strep vaginal and rectal cultures (35-37 weeks)
- Neural tube defects screen (offered, but not required)
- Syphilis screen (initial, between 28 and 30 weeks[+] and at delivery)
- Chlamydia screen (initial and repeat in 3rd trimester if <25 years old or high risk[+])
- Gonorrhea (initial and at delivery if high risk)[+]
- Cervical cytology (as needed)
- Hepatitis B virus surface antigen (initial and repeat late in preganancy if HbsAg negative, but high risk for HBV infection)
- HIV (recommended with patient consent at initial)
- Additional tests as needed on the basis of the patient's history

Non-Routine Testing

- **Ultrasound** for specific indications at various gestational ages, such as at 16-18 weeks of gestation for mothers with diabetes mellitus or at 32-34 weeks of gestation to assess fetal growth restriction for women at high risk. Repeated or planned serial ultrasound examinations may be indicated, such as for women with D (Rh) isoimmunization or other causes of fetal hydrops.
- **Antibody Testing** repeated in an unsensitized, D-negative patient at approximately 28 weeks of gestation. If negative, the patient should receive D (Rho [D]) immune globulin prophylactically. In addition, D-negative patients should receive D immune globulin if they have had one of the following:
  - Ectopic gestation
  - Abortion (either spontaneous or induced)
  - Procedure associated with possible fetal-to-maternal bleeding, such as chorionic villus sampling (CVS) or amniocentesis
  - Condition associated with fetal-maternal hemorrhage (e.g., abdominal trauma, abruptio placentae)
  - Delivery of a D-positive infant
- **Maternal Infection Testing** for those whose history suggests increased risk. Test for Hepatitis C (HCV) and other infections as needed based on the patient's history.
- **Diabetes Screening:** Screening for gestational diabetes can be universal or selective, and should be performed at 24-28 weeks of gestation. For selective screening, the following risk factors may be used:
  - Family history of diabetes in first degree relatives[H]
  - Previous birth of a macrosomic, malformed or stillborn baby
  - Hypertension
  - Glycosuria
  - Maternal age ≥25 years[H]
  - Previous gestational diabetes
  - <25 years of age and obese (i.e., ≥20% over desired body weight or BMI ≥27 kg/m2) [H]
  - Member of an ethnic/racial group with a high prevalence of diabetes[H]
- **Maternal Serum Screening:** Women <35 years of age should be offered serum screening to assess the risk of Down Syndrome, ideally between 15 and 18 weeks of gestation. In women ≥35 years of age, multiple marker testing cannot be recommended as Down Syndrome. Serum screening for neural tube defects by MSAFP (maternal serum alpha-fetoprotein) testing should also be offered to all pregnant women; ideally between 15 and 18 weeks of gestation.

H Recommended for gestational diabetes by the American Diabetes Association.
+ State of North Carolina Administrative Code (10A NCAC 41A.0204 (e)) requirement.

Risk Assessment and Management

Examinations

1) **Prenatal Diagnosis of Genetic Disorders in Patients at Increased Risk:** Prenatal genetic screening should be voluntary and informed. For straightforward genetic disorders, a primary care physician may perform counseling. A referral to a geneticist may be necessitated by the complexities of determining risks, evaluating a family history of such abnormalities, interpreting laboratory tests, or providing counseling.

   Diagnostic Testing:

   - Amniocentesis - (usually performed around 16 weeks of gestation)
   - Chorionic Villus Sampling or CVS - (usually performed between 10 and 12 weeks of gestation)
   - Testing D-Negative Women - (Because both amniocentesis and CVS can result in fetal-to-maternal bleeding, the administration of D immune globulin is indicated for D-negative, unsensitized women who undergo either of these procedures.)

2) **Fetal Well-Being / Surveillance:** Testing may be indicated for the following: decreased fetal movement, hypertensive disorders, insulin-dependent diabetes mellitus, oligohydramnios or hydramnios, fetal growth restriction, post-term pregnancy, or multiple gestation with discordant fetal growth. In most clinical situations, a normal test result indicates that intrauterine fetal death is highly unlikely in the next 7 days. An abnormal result or nonreassuring fetal status is associated with a high rate of false-positive results, based on clinical situation require additional testing to corroborate or refute.

   Diagnostic Testing:

   - Assessment of Fetal Movement (*e.g., kick counts*)
   - Nonstress Test
   - Contraction Stress Test
   - Biophysical Profile
   - Modified Biophysical Profile

3) **Risk Assessment for Preterm Labor:** Risk factors associated with spontaneous preterm labor and birth (The prevention of preterm birth remains controversial and no clear course of treatment has been established.):

Past Pregnancy	*Current Pregnancy*
Preterm birth	Hydramnios
Midtrimester spontaneous abortion	Second- or third-trimester bleeding
Known uterine anomaly	Preterm labor
Exposure to diethylstilbestrol	Preterm premature rupture of membranes
Incompetent cervix	Multiple gestation
	Preterm cervical dilatation of ≥2 cm in a multipara and ≥1 cm in a primipara
	Prepregnancy weight <115 pounds
	Age <15 years

4) **Post-term Gestation:** In most instances, a patient is a candidate for induction of labor if the pregnancy is at greater than 41 weeks of gestation and the condition of the cervix is favorable. If the cervix is not favorable, a test of fetal well-being should be performed, and delivery effected if the test is nonreassuring.

Key Process and Outcome Measures (Indicators for All Pregnancies)

- Blood Group and CDE (Rh) Testing
- Antibody Screening
- Hct / Hgb Testing
- Pap Testing
- MSAFP Testing
- Rh Screening (for Rh negative mother)
- Diabetes / Glucose Screening
- Rubella Screening
- VDRL Screening
- Urine Culture / Screening
- HBsAg Testing
- HIV Testing
- Maternal Complications at Birth
- Fetal Complications at Birth
- Premature Birth

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Generic Drug Copayment Waiver Through December 31, 2004

Last year, Americans spent more than $180 billion on prescription drugs. While the increased use of prescription drugs has helped improve the health and quality of life for many people, the high cost of brand-name drugs has also contributed to an overall increase in the cost of health insurance premiums.

That's just one reason why Blue Cross and Blue Shield of North Carolina (BCBSNC) encourages its members to learn the facts about generic drugs – especially the fact that generics usually sell for 30 to 70 percent less than their brand-name counterparts.

From October 1, 2004, through December 31, 2004, BCBSNC will waive members' copayments for both new and refilled generic prescription drugs (Formulary Tier 1). Members just need to present their BCBSNC ID card and a prescription for a generic drug at a participating network pharmacy in order to obtain the copayment waiver.

We recognize that the choice of appropriate medication should be based on your knowledge and understanding of the patient and their condition. However, we hope you will encourage your patients to learn more about the benefits and cost-effectiveness of generic drugs, when appropriate.

**Except for members of the State Health Plan, the Federal Employee Program and self-insured (ASO) groups that have carved out their prescription drug coverage benefits.*