BlueLINK SM

News from Blue Cross and Blue Shield of North Carolina

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BlueCross BlueShield of North Carolina

BCBSNC Launches Healthy Lifestyle Choices

(P) (F)

With more than half of Blue Cross and Blue Shield of North Carolina (BCBSNC) members overweight or obese, BCBSNC recently announced Healthy Lifestyle Choices[SM1], a comprehensive program to help members achieve a healthier weight and engage in lifestyle changes that can avoid serious – and costly health problems.

More than 1.1 million North Carolinians will be eligible for the Healthy Lifestyle Choices program that includes new benefits and additions to preventive care programs. These benefits will be considered standard for employer groups and individuals enrolled in Blue Care®, Blue Options[SM] or Blue Advantage® products. Highlights include:

- Coverage for four physician office visits per year and related testing for the evaluation and treatment of obesity (effective April 1, 2005, at group renewal).
- Coverage of two U.S. Food and Drug Administration (FDA)-approved, prescription weight-loss drugs for the long-term treatment of obesity – Meridia and Xenical – when medically necessary (effective October 1, 2005, at group renewal).
- Credentialing and contracting with licensed registered dieticians to include their services in the treatment of obesity (effective October 1, 2005, at group renewal).

Benefits of Choosing Healthy Lifestyle Choices

Beginning in early 2005, eligible members who choose Healthy Lifestyle Choices will be provided with educational materials and self-help tools, such as pedometers, a lifestyle diary and access to an interactive online weight-loss program. This free self-management program encourages safe and effective weight loss, improved eating habits, physical activity and stress management.

Members will initially be invited to participate in the program based on claims diagnosis of certain weight and lifestyle-related conditions, such as hypertension, diabetes and cholesterol disorders. Members will also be able to self-refer into the program by spring 2005.

Prior to developing the program, BCBSNC examined claims data and surveyed several thousand members to find that many people just don't see excess pounds as a health threat. We sought input from doctors across the state and from national preventive health experts including William H. Dietz, MD, director of the Centers for Disease Control and Prevention's (CDC's) Division of Nutrition and Physical Activity.

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Provider-Specific Member Satisfaction Survey

Blue Cross and Blue Shield of North Carolina (BCBSNC) conducts annual provider-specific member satisfaction surveys to find out if our members are pleased with the care they receive from their doctor and if they are satisfied with their health plan.

Recent survey results show that our members are generally pleased with their access to care and are satisfied with the service they receive from BCBSNC. In 2004, 93.7 percent of respondents reported being satisfied or very satisfied with their overall care and attention from their doctor and BCBSNC.

Time Spent in Waiting and Exam Rooms – Still a Dissatisfier

Members' responses also help us identify potential areas for improvement. For instance, recent survey results revealed that 92.9 percent of members were generally satisfied with the time required to get an appointment with their doctor for a routine visit. However, only 76.6 percent of members were satisfied with the amount of time spent in the waiting room after arriving for an appointment. This is clearly an area for improvement.

Based on the continued low satisfaction rate with waiting room time, additional questions were asked in hopes of determining the cause. Of the members responding, over one third reported waiting longer in the exam room than in the waiting room. Thirty-five percent reported waiting 10 to 15 minutes and almost 17 percent reported waiting 16 to 30 minutes in the exam room. Although there is no specific standard for exam room waiting time, we would encourage you to be acutely aware of how long your patients are left unattended in the exam room, as this is a significant patient dissatisfier.

Two other areas for improvement to note are: 1) assistance/advice given by telephone during regular office hours, and 2) the amount of time required for return calls after regular office hours. Members reported being satisfied or very satisfied – 87.8 percent and 83.8 percent respectively – on these two survey questions. We realize that responses to the assistance/advice question are subjective in nature, but feel it is important to bring the issue to your attention. Please note that there are standards in place for returning calls after hours of which all physicians should be aware. Those standards are 20 minutes for an urgent need and one hour for a non-urgent need.

If you have suggestions regarding any of these issues, we would like to hear from you. We would especially welcome your suggestions on how to improve member/patient satisfaction regarding time spent in the waiting room or exam room. You may submit suggestions via e-mail to us at ***quality@bcbsnc.com*** or in writing to us at:

BCBSNC
c/o Manager, Continuous Quality Improvement
P.O. Box 2291
Durham, NC 27707

BCBSNC Launches Healthy Lifestyle Choices (continued from page 1)

"This program represents a direction that a lot more health insurers could pursue," said Dr. Dietz. "Clearly, Blue Cross and Blue Shield of North Carolina is making a serious commitment of resources to support its members in their efforts to manage their weight."

The Costs of Obesity

Unhealthy weight often leads to serious health problems such as high blood pressure, diabetes, heart disease and arthritis. Treating those diseases contributes to rising medical costs. Overweight and obesity accounted for $83.1 million in excess costs to BCBSNC in 2003. Obese members incur 32 percent more in claims and medical expenses than normal-weight members.

"Even a modest weight loss of 5 to 10 pounds and increased activity can save lives and millions of dollars in health care costs," said Dr. Robert T. Harris, chief medical officer for BCBSNC. "Making the connection between weight and health will make a difference, and we think the doctor's office is the right place to start this discussion." BCBSNC will send information and resources to doctors encouraging discussions with your patients about how they can achieve a healthier weight.

Bariatric Surgery Centers of Excellence

Additionally, BCBSNC has identified 12 doctors in seven practices across the state as demonstrating superior results in bariatric surgery. Those practices, along with the facilities where the procedures are performed, have been identified as Bariatric Surgery Centers of Excellence. Members can obtain a list of these centers by clicking on the "Find a Doctor" button on the BCBSNC home page at ***bcbsnc.com*** and entering "obesity" in the specialty search field.

If you would like more information to share with your BCBSNC patients about the Healthy Lifestyle Choices program, please e-mail your request to ***quality@bcbsnc.com***.

Member Privacy and Confidentiality

At Blue Cross and Blue Shield of North Carolina (BCBSNC), we take our duty to safeguard the privacy and security of our members' protected health information (PHI) very seriously, as we know you do too. In connection with recent developments concerning the law of privacy and security of PHI, including the HIPAA Privacy and Security Rules and the North Carolina Consumer and Customer Information Privacy Act, we have updated our corporate privacy policies and procedures accordingly. The highlights of these policies are described below. As contracting providers, it is important that you understand how we protect our members' health information.

- We protect all personally identifiable information we have about our members, and disclose only the information that is legally appropriate. Our members have the right to expect that their PHI will be respected and protected by BCBSNC.
- Our privacy and security policies are intended to comply with current state and federal law and the accreditation standards of the National Committee for Quality Assurance. If these requirements and standards change, we will review and revise our policies, as appropriate. We also may change our policies (as allowed by law) as necessary to better serve our members.
- To make sure that our policies are effective, we have designated a Chief Privacy and Security Official and a Privacy and Security Committee that are charged with approving and reviewing BCBSNC's privacy and security policies and procedures. They are responsible for the oversight, implementation and monitoring of the policies.

Our Fundamental Principles for Protecting PHI

- We will protect the confidentiality and security of PHI, in all formats, and will not disclose any PHI to any external party except as we describe in our privacy notice or as permitted or required by law or regulation.
- Each of our employees receives training on our policies and procedures and must sign a statement when they begin work with us, acknowledging that they will abide by our policies. Only employees who have legitimate business needs to use members' PHI will have access to personal information.
- When we use outside parties (business associates) to perform work for us, as part of our insurance business, we require them to sign an agreement, stating that they will protect our members' PHI and will only use it in connection with the work they are doing for us.
- We communicate our practices to our members through our privacy notice, member magazine articles, and during the enrollment process they follow when becoming a BCBSNC member.
- We will disclose and use PHI only where required or permitted by law or to honor a member's authorization request.
- We will respect and honor our members' rights to: inspect and copy their PHI, amend or correct the PHI we maintain about them, request a restriction on use and disclosure of PHI, request confidential communications, file a privacy complaint, request an accounting of disclosures and request a copy of our Notice of Privacy Practices.

Please read our Notice of Privacy Practices for more information about our privacy policies. Please visit our Web site at ***bcbsnc.com***, for the most current version.

Interested in Becoming a Medicaid Provider?

Medicaid covers more than 1 million North Carolinians who are in need of financial assistance for their health care services. The North Carolina Division of Medical Assistance (DMA) administers the state's Medicaid program.

If you are a new provider and are interested in participating in the North Carolina Medicaid program, you must enroll through the DMA. Previously, Blue Cross and Blue Shield of North Carolina (BCBSNC) handled the enrollment of providers in the Medicaid program. **Effective January 1, 2005, the enrollment process will now be handled by the DMA.**

You can obtain the necessary application and enrollment change forms online at the DMA Web site at ***www.dhhs.state.nc.us/dma***. Information is also available in the December 2004 *Medicaid Bulletin*, or you can contact DMA Provider Services at (919) 855-4050 if you need further assistance.

Please note that in the future you will need to notify both DMA and BCBSNC when demographic changes are necessary. Keeping demographic information up-to-date is critical in order to ensure appropriate notification and payment of claims.

BCBSNC 2004 HEDIS Rates

We are pleased to provide you with the 2004 HEDIS* and member satisfaction survey results for Blue Cross and Blue Shield of North Carolina (BCBSNC). As in past years, BCBSNC consistently performed above the national average for most measures. Measures falling below the national average included cholesterol management after a cardiac event, chlamydia screening rates, adolescent immunization rates, and follow-up after hospitalization for mental illness (seven-day stay). These are areas in which BCBSNC has and will continue to address through our quality improvement program.

If you have any questions or ideas to assist us in our HEDIS effort, please contact your BCBSNC Quality Management consultant. If you would like a copy of our Quality Improvement Program, please e-mail us at ***quality@bcbsnc.com***. We value your input and appreciate the effort our physicians make to provide outstanding quality care to our members.

The table below illustrates 2004 results for HMO and POS health plans compared to last year and to the 2004 national average, as reported by the NCQA 2004 Quality Compass. Member satisfaction scores for our PPO plan are also provided.

**HEDIS is a set of health care measurements designed to allow comparison among health plans in effectiveness of care, availability of care and utilization. HEDIS is a registered trademark of the National Committee for Quality Assurance.*

Performance Measure	*BCBSNC 2003 Rates (2002 data)*	*BCBSNC 2004 Rates (2003 data)*	*2004 National Average*
Childhood Immunizations			
Combination Rate 1	83.4	84.4	74.4
Combination Rate 2	78.1	81.6	69.8
Adolescent Immunizations			
Combination Rate 1	53.3	53.3	58.7
Combination Rate 2	17.0	22.4	41.6
Breast Cancer Screening (Mammography)	79.2	79.2	75.3
Cervical Cancer Screening (Pap Test)	85.8	86	81.8
Chlamydia Screening in Women	18.5	22.3	29.7
Beta Blocker After a Heart Attack	92.6	91.9	94.3
Cholesterol Management After a CV Event			
Screening	79.6	78.1	80.3
LDL-C Level (<130 mg/dL)	61.8	62.8	65.1
Comprehensive Diabetes Care			
HbA1c Screening	83.2	88.8	84.6
Poor HbA1c Control	29.7	28.7	32
Eye Exams	47.0	46.7	48.8
LDL-C Screening	85.4	87.4	88.4
LDL-C Control (< 130 mg/dL)	56.0	62.0	60.4
Nephropathy Monitoring	51.3	53.0	48.2

(Continued on page 5)

BCBSNC 2004 HEDIS Rates (continued from page 4)

Performance Measure	*BCBSNC 2003 Rates (2002 data)*	*BCBSNC 2004 Rates (2003 data)*	*2004 National Average*
Controlling High Blood Pressure	67.6	68.0	62.2
Use of Appropriate Medications for People With Asthma	70.6	70.7	71.5
Antidepressant Medication Management			
Optimal Practitioner Contacts	13.8	17.6	20.3
Effective Acute Phase Treatment	58.4	59.0	60.7
Continuation Phase Treatment	43.9	42.8	44.1
Follow-Up After Hospitalization for Mental Illness			
Within 7 Days of Discharge	45.8	44.5	54.4
Within 30 Days of Discharge	69.9	72.1	74.4
Timeliness of Prenatal Care	92.2	92.2	89.4
Timeliness of Postpartum Care	90.9	90.9	80.3
Member Satisfaction Survey - HMO and POS Products			
Rating of Personal Doctor or Nurse	77.5	76.4	76.2
Rating of Specialist Seen Most Often	83.3	80.7	77.06
Rating of All Health Care	84.5	81.0	76.3
Rating of Health Plan	68.8	66.1	61.8
Member Satisfaction Survey – PPO Product			
Rating of Personal Doctor or Nurse	83.6%	83.7	NA
Rating of Specialist Seen Most Often	78.9%	79.7	NA
Rating of All Health Care	81.9%	82.7	NA
Rating of Health Plan	65.3%	63.9	NA

Pre-Existing Reviews and Requests for Medical Information

BCBSNC recently concluded a study to determine the value of administering pre-existing condition waiting periods to learn if there were ways to simplify the administration of benefits for our members and providers.

As a result of this study, effective January 1, 2005, we will streamline the pre-existing condition medical review process by reducing the frequency of medical record requests to providers. This will permit speedier payment of claims to both providers and members.

Please do not send unsolicited medical records to BCBSNC, and always complete the BCBSNC record request form provided by BCBSNC when sending requested records.

Streamlining the EOB Process for Our Members

As part of Blue Cross and Blue Shield of North Carolina's (BCBSNC's) ongoing commitment to streamline our business processes, we will soon change when Explanation of Benefits (EOBs) are mailed to members. **Providers will continue to receive Notification of Payments (NOPs) and Explanation of Payments (EOPs) in the same manner you do today.**

Last year alone, BCBSNC mailed out over nine million EOBs to members. Approximately 70 percent of the EOBs that we send to members are for services for which a member either owes nothing at all or only had to pay a copayment. Since you collect the patient's copayment at the time of service and the member owes nothing more on these services, the resulting EOB is probably of little or no value to the patient.

As a result, beginning in 2005 upon the member's employer group renewal date, we will no longer mail EOBs to members when there is no additional member liability involved. Some examples of claims that will result in an EOB continuing to be mailed are:

- Claims that require a payment from the member, excluding copayments.
- Claims with any member liability, including:
  - Claims from nonparticipating providers.
  - Claims with a deductible, coinsurance or penalty payment.
  - Claims that have been denied, but the member is responsible for the denied charges.
- Claims filed by the member.
- Claims that have been adjusted.
- Claims that require secondary coordination of benefits.

If a member requires a copy of an EOB, they can call BCBSNC Customer Service at the toll-free number on their ID card and request that a copy be mailed to them, or they can use "My Member Services" online at ***www.bcbsnc.com*** to view EOB information on a specific claim.

If you have any questions regarding this change, please contact your local BCBSNC Network Management office.

Access to Behavioral Health Care

BCBSNC, in conjunction with the Provider Advisory Group, has developed access to care standards to monitor the accessibility of behavioral health services for our PPO members. The standards for behavioral health appointment wait times are as follows:

- **Life-Threatening Emergency: Call 911 or go directly to the emergency room**
- **Care for a Non-Life-Threatening Emergency: Within 6 hours**
- **Urgent Care: Within 48 hours**
- **Routine Office Visit: Within 10 business days**

BCBSNC collects and analyzes data to measure our network providers against the access to behavioral health care standards. To be consistent with the standards for our HMO network provided through Magellan Behavioral Health, the following Plan performance goals have been set:

- 95 percent of providers will be in compliance with both the emergency and the urgent care wait times.
- 85 percent will be in compliance with the routine care standard.
- Providers having seen 50 or more BCBSNC PPO members in the two years preceding the review are questioned to determine compliance to these standards.

In August 2004, 99 practices were identified as meeting the criteria for review. Of those practices, only 44.4 percent reported seeing patients with a non-life-threatening emergency within six hours. Seventy-five practices (75.8 percent) reported being able to see patients with urgent needs within 48 hours and 77 practices. Seventy-seven practices (77.8 percent) could schedule a routine appointment within 10 business days. Feedback has been provided to each practice not meeting one or more of the above standards, and they will be re-audited for compliance in December.

Why Is It Important to Complete a W-9 Form?

Blue Cross and Blue Shield of North Carolina (BCBSNC) uses the information completed on the W-9 form to pay providers and file payment information to the Internal Revenue Service (IRS). If the name or tax identification number is incorrect on the form and BCBSNC files this incorrect information with the IRS, we are subject to penalties and you may be subject to back-up withholding of 28 percent. In addition, you may be subject to a $50 penalty. Here are some questions and answers that we hope will help you successfully fill out your next W-9 form.

What does "Tax Status" mean on the W-9 form?

The term "Tax Status" refers to the tax entity under which taxes are filed. For an individual or sole proprietor tax status, the income is filed on Form 1040. Other tax statuses would file the appropriate return based on their status. For example, a corporation would file a corporate return.

Am I exempt?

For medical services, corporate tax status does not qualify as exempt. Only 501 (c) (3) or 501 (a), governmental agencies, state or political subdivisions or foreign governments qualify as exempt. On the W-9 form, the type of exemption must be checked.

What is my legal name?

Your legal name is related to the tax status. For an individual or sole proprietor tax status, the IRS can only match your individual name with your Social Security number (SSN) or employer identification number (EIN). It generally cannot match your "Doing Business As (DBA)" name or trade name. On the substitute W-9 form designed by BCBSNC, there is a separate line to add a DBA name if you are an individual or have sole proprietor tax status.

The legal name of a partnership, corporation or other entity would be the name on the charter or other legal document that was also on the original filing with the IRS to receive an EIN.

For verification of your legal name and tax ID number, you may also refer to preprinted labels from the IRS on documents such as payroll deposit coupons or income tax returns.

What address should be used on the W-9 form?

You should use the address to which you wish payments to be sent. If there is a different address for correspondence and 1099-MISC forms, this should be clearly indicated on the form.

What is my taxpayer identification number (TIN)?

A TIN is either a Social Security number (SSN) or an employer identification number (EIN). An individual can only use an SSN. A sole proprietor tax status could use either an SSN or EIN, if an EIN was assigned by your request from the IRS. Partnerships, Corporations, LLCs, etc. must apply to the IRS for an EIN and this is what should be used on the W-9 form. List only one, but not both.

What does "Date Employer ID Number Was Assigned by IRS" mean?

This is the effective date of the EIN and the legal name you are providing on the W-9 form. This date is important if there is a split between the new and old entities for the current tax year.

Why should I review my 1099-MISC form?

BCBSNC mails 1099-MISC forms to recipients on or before January 31 each year. As a recipient, it is important to review the information printed on the 1099-MISC form. If any of the data is incorrect, please call the phone number provided so that we can correct our databases, as well as the file, which will go to the IRS.

Why is BCBSNC saying that my name and tax ID number (TIN) combination does not match the IRS files?

BCBSNC generally files 1099-MISC form data to the IRS in April. The 1099-MISC forms are mailed to recipients on or before January 31. It is assumed that if the recipient has not contacted BCBSNC that the information on the form is correct, and this is what will be filed to the IRS. In early fall of the current year, the IRS notifies filers of "mismatches" for the prior tax year. This listing is called a "B-Notice." There are regulations governing how filers handle these B-Notices, including a mailing to recipients identified on this notice requesting documentation of the recipient's legal name and TIN.

State Health Plan Briefs

New ID Numbers For State Health Plan and NC Health Choice Members

Over the next few months, we will start the process of converting State Health Plan and NC Health Choice member ID numbers to a non-Social Security number. This is part of the nationwide conversion process to remove Social Security numbers from member ID cards. The new ID numbers will consist of the lead alpha character (W) followed by 10 numeric digits. An example of a new ID number would be W21459837-0-1.

Mailbacks

We continue to see a high volume of claims that have to be mailed back because of missing or incomplete information. The top five reasons your State Health Plan claims are mailed back are:

- Provider number missing or invalid
- Member ID number invalid
- Admit and discharge dates are missing
- Onset date is missing
- Units are missing or are incorrect for type of service reported

To avoid delays in the processing of your claims, it is imperative that they be filed with complete and accurate information.

New Claim vs. Corrected Claim

We continue to 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 paid or denied as indicated on your Notification of Payment (NOP), and for which you are making a correction. 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. Stamping "corrected claim" or changing the bill type on a claim that has never been processed does not expedite processing. In fact, this could delay processing because the claim has to be rebatched and forwarded to the State Health Plan Claims Department.

When submitting a "true" corrected claim, professional providers should be sure to stamp or write "corrected claim" on an area of the claim so that it is clearly visible. Institutional providers should use the appropriate bill type, as listed below, to indicate they are filing a corrected claim.

Bill Type 115 – Late charges-only claim

Bill Type 116 – Adjustment to a prior claim

Bill Type 117 – Replacement of prior claim

State Health Plan Coverage and Medicare Part B

When a State Health Plan member is eligible for Medicare Part B (medical) due to disability, end-stage renal disease (ESRD), retirement or reaching age 65, it is recommended that they enroll in Medicare Part B. If a State Health Plan member chooses not to enroll in Medicare Part B, the Plan estimates the amount that Medicare would have paid for covered services and considers for Plan payment only the remaining balance just as if Medicare had paid.

For example, if we receive a claim for $50 and the member chose not to enroll in Medicare Part B, our allowance would be $10 ($50 x 20 percent) and we would pay 80 percent of $10. Our payment on the $50 claim would be $8 ($10 x 80 percent). The patient would be responsible for the difference up to the allowable amount. It is very important that you check with your patients to make sure that they are in enrolled in Medicare Part B.

Coordination of Benefits

When a patient has both State Health Plan and BCBSNC coverage, you must first file a claim directly to the primary carrier. Upon receipt of the primary carrier's payment, submit the claim along with the primary carrier's Explanation of Benefits (EOB) to the secondary carrier. Claims received without the EOB will be denied.

Please do not put any information in the "other carrier" field if the State Health Plan or NC Health Choice patient has no other coverage. Putting information in this field, in the absence of other coverage, delays the processing of the claim.

Claims Spanning the End of the Fiscal Year

Claims submitted to the State Health Plan (SHP) with services that span the end of the fiscal year (July 1 through June 30) cannot be processed for payment and will be denied. The claims have to be split and corrected claims submitted. Please note that claims submitted to the State Health Plan that are reimbursed based on the diagnosis-related group (DRG) methodology and Medicare Part A (hospital) claims do not have to be split if they span the fiscal year.

Ambulance Claims

The State Health Plan requires that the HCPCS code, units (or miles), and appropriate modifier be included on ALL ambulance claims. Claims that are submitted without this information will be mailed back to the facility for correction. Please note that air ambulance and licensed land ambulance over 50 miles requires prior State Health Plan approval.

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Modifier 24

The State Health Plan does not recognize modifier 24 (unrelated evaluation and management (E&M) service by the same physician during a postoperative period). If you file for an E&M service with a modifier 24, we must have a copy of the office notes in order to determine if the services is payable.

Medical Review Implements a Discharge Planning Program

Beginning October 1, 2004, State Medical Review implemented a discharge planning program. State Medical Review will make pre- and post-operative telephone calls to members who have the following surgeries:

- Coronary Artery Bypass Graph (CABG)
- Total Knee Replacement
- Total Hip Replacement
- Multiple Level Lumbar Laminectomy
- Gastric Bypass Surgery

Discharge planning is a collaborative process that assists the patient and his or her family with the transition from a higher to lower level of care. Our purpose is to be proactive in anticipating needs for services requiring authorization and to provide member education. A nurse helps to coordinate options and services to meet the patient's health needs. A nurse from the Claims Processing Contractor will contact patients scheduled to be admitted to the hospital for these surgeries before the admission in order to plan for care coordination after discharge from the hospital.

A nurse will also call the patients after discharge to offer assistance with the transition from the hospital to home or other setting. Discharge planning services may also be offered to patients who are leaving the hospital after admission for a serious illness or injury. Additionally, we will begin short-term case management (four to six weeks) for members having catastrophic illnesses who need additional help in managing their care. These services are offered at no cost to the patient.

What Is A Retrospective Review?

The Medical Review Department offers a review for coverage of health care services after a patient receives the service. This is called retrospective review. Retrospective review decisions are based on medical necessity and whether or not the service received was a benefit under the Plan. The Medical Review Department makes all retrospective review decisions within 30 days of receiving all necessary information. Medical Review will notify you and the member in writing within five business days after a decision has been made. If the service is denied, the member may then file an appeal within 60 days from the date of the denial letter from Medical Review.

For all retrospective reviews, please submit documents directly to:

State Medical Review
P.O. Box 30111
Durham, NC 27702-30111

Or fax to us at (919) 765-4890

To avoid delays with requests for review, we encourage you to submit medical records as soon as possible upon receiving notification that records are needed. If you have any questions, please feel free to contact State Customer Services at **1-800-422-4658**, and a representative will be happy to assist you.

Important Things to Remember When Submitting an Appeal

1. Many problems or concerns can be resolved through Customer Services without going through the formal appeal/grievance process. If you disagree with the courtesy review decision, you may then submit a formal appeal.
2. When requesting an appeal/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 a benefit determination/decision.
3. When medical records are requested, send all of the requested information, within the time frame specified, to the State Health Plan appeals analyst who requested the information. Failure to submit information timely may result in the continuation of the denial.
4. If a corrected claim needs to be submitted in relation to or in support of claim of a denial, send the corrected claim to State Health Customer Services prior to initiating an appeal/grievance, keeping in mind the 60-day time frame.
5. If a claim is denied for noncertification, and additional information is available, you can request reconsideration within 30 days. Noncertification and appeal/grievance letters are very specific regarding criteria that were not met. Providers should target providing information in support of the non-met criteria when requesting additional review.
6. To inquire about the status of an appeal (if you did not initiate it with proper authorization), you must have authorization from the member. The appeal process is different from the inquiry process and

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different procedures apply once a case becomes a formal appeal or grievance.

7. Information regarding medical policies, SHP appeal and grievance procedures, the member's benefit booklet, and forms can be found on the State Health Plan (SHP) Web site at ***www.statehealthplan.state.nc.us.***

Prescription Drug Claims

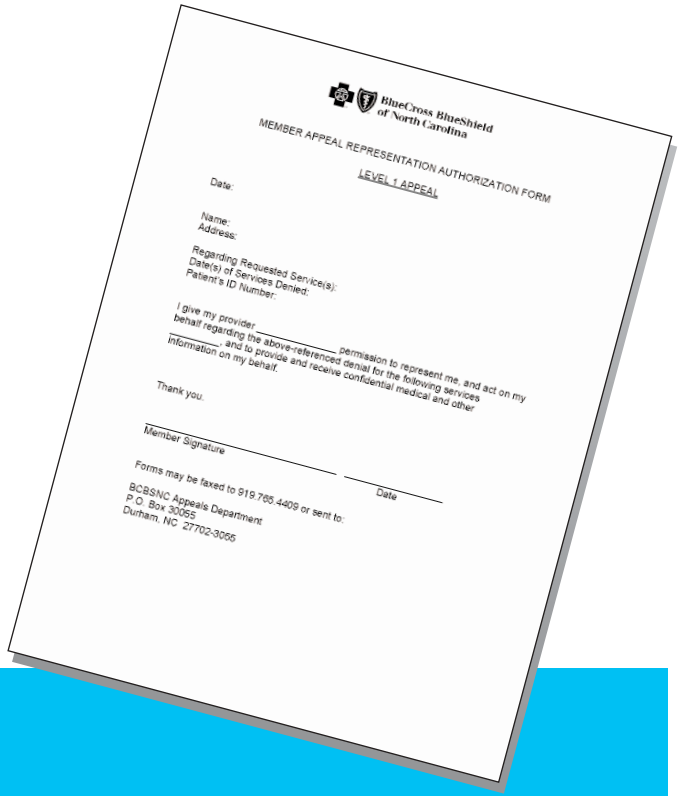
If a pharmacy reverses a previously submitted claim through the State Health Plan's pharmacy benefit manager (PBM), the claim must be adjusted and the money reversed. A report is generated by the PBM and sent to the Plan. The Plan manually makes an internal adjustment to the claim to reflect the refund received by the PBM. If the money was paid to the member, a refund request is needed. Most of the claims on the reversal report are generally duplicate claims submitted for the same date of service, for the same amount billed, but for different days supply. Pharmacists should be careful to submit the correct days supply to avoid the need for a reversal.

Member's Appeal Representation Authorization Form Level I Appeal

The Health Insurance Portability and Accountability Act (HIPAA) changes the way in which health care companies and medical care providers are permitted to use and disclose information about our members. BCBSNC has always been committed to protecting our members' health information, and now we are implementing additional policies and procedures to safeguard their information. Please read the *Notice of Privacy Practices* on our Web site as it explains our practices concerning members' protected health information in detail.

In addition, because of the new federal regulations, we want to highlight the following important changes:

- As described in the *Notice of Privacy Practices*, a member may authorize another person to receive their protected health information.
- As of April 14, 2003, we are no longer permitted to give our members' protected health information to another person unless we have legal permission. One way they can give us permission is to sign a document called an "Authorization." BCBSNC will no longer release information to another person other than the member unless we have a signed authorization from them.
- As of November 1, 2004, we created an electronic **Member Appeal Representation Authorization Form** for your convenience, which you can print out and give to your patient for his/her signature.
- To locate the form, go to ***www.bcbsnc.com*** under "Provider Resources."


BlueCross BlueShield of North Carolina

MEMBER APPEAL REPRESENTATION AUTHORIZATION FORM

LEVEL 1 APPEAL

Date:

Name:
Address:

Regarding Requested Service(s):
Date(s) of Services Denied:
Patient's ID Number:

I give my provider _____ permission to represent me, and act on my behalf regarding the above-referenced denial for the following services _____; and to provide and receive confidential medical and other information on my behalf.

Thank you.

Member Signature _____ Date _____

Forms may be faxed to 919.765.4409 or sent to:
BCBSNC Appeals Department
P.O. Box 30055
Durham, NC 27702-3055

Claims Filing Reminders: Place of Service

We are currently receiving claims with the incorrect place of service code. Please note that the correct place of service code for "Doctor's Office" is 11. Please refer to the following list for correct place of service codes:

11	Doctor's Office
12	Patient's Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or Water
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

DME Claim Filing Reminders

Professional providers filing claims for durable medical equipment must include their provider number in block 24k on the CMS 1500. If a group or clinic number is placed in field 33, a provider number is also needed in field 24k.

Please remember that durable medical equipment (DME) maintenance and repairs may only be billed for purchased equipment with appropriate HCPCS codes and not for rented equipment. Prior Plan approval must be obtained for certain items (specific list of codes available from BCBSNC Customer Service, Medical Resource Management or your Network Management representative). This list includes items that were purchased prior to August 1, 2003, but are now classified as rental items and are still being provided to a Blue Care or Blue Choice member (Blue Options and Classic Blue® plans do not require prior Plan approval for DME).

Update on BCBSNC Plan to Transition to New Member ID Numbers

We continue to move ahead with our effort to protect our members from identity theft by issuing new member ID numbers that do not contain Social Security numbers (SSNs). We are on track to start transitioning members to the new ID numbers beginning in March 2005, and anticipate that members will have new ID cards to present to their providers by April 1, 2005. We will continue to transition members upon their renewal date until all members have been issued a new member ID number by January 1, 2006.

There is one update from our last communication to you. The ID number on the ID card will be reformatted to remove all spaces and dashes from the number. For example, the new ID number will appear as shown on the sample ID card below:

(3-digit prefix followed by W and 8 digits – no spaces or dashes)

Helpful Tips

All BCBS Plans are eliminating the use of SSNs as the member ID number. You have probably already encountered patients covered by Plans that have already issued their new identifier. The following tips will be helpful to you in ensuring a smooth transition:

- First, 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, you may want to 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 three-character alpha prefix, and pass this key information to your billing staff.
- The member ID will always include the alpha prefix in the first three positions.
- Following the three-character alpha prefix, the ID card may include any combination of alpha/numeric characters (letters or numbers) for a maximum length of 17 characters total (3 character alpha prefix + up to 14 alpha/numeric characters). You may see cards with ID numbers that are fewer than 17 characters in total.

  (Note: BCBSNC's number following the prefix will always be W + 8 numeric digits. The 2-digit dependent number will be displayed next to the member's name on the card and should be appended to the ID number.)
- Notify your vendors and clearing houses of the new ID number formats to ensure that they are prepared to accept the new ID.

For more information, you can go to ***bcbsnc.com*** and click on "Important News" on the "I'm a Provider" home page.

BlueCard® Q & A

Thanks to those of you who took the time to e-mail us your BlueCard questions. Our BlueCard Department has provided answers to the questions we received from you. If you have any additional BlueCard questions that you would like to submit, please send them to *Susan.Lovett@bcbsnc.com*.

Q. When an out-of-state member receives services in North Carolina, which Plan's medical guidelines are followed? For example, a patient has BCBS of NY, which pays for any type of doctor for diagnostics, but BCBSNC only covers cardiologists. Are the services denied even though the Home Plan covers the service in question?

A. No, the claims are passed to the Home Plan, which will determine the benefits. BCBSNC also sends the contracted rate for the service in question to the Home Plan.

Q. Please provide any helpful tips on getting BlueCard secondary paper claims processed on the first filing. Also, how do we keep the primary EOB from getting lost?

A. We are currently trying to determine why providers are having such difficulty getting reimbursement when a claim involves coordination of benefits (COB). We understand that this is an issue and are working to resolve it as soon as possible.

Q. How do I avoid getting a claim that was incorrectly denied on the first filing through the second time without it being denied as a duplicate?

A. Do not refile the claim. If you receive a Notification of Payment from us, we have your claim on record. Contact our BlueCard Customer Service Department, and we will assist you in getting the answer you need to your claim question.

Attention Home Infusion Therapy and Specialty Pharmacy Providers: Billing and Claims Policy for Drugs

We're finding that many of you still have questions about drug pricing, so we thought we would share the following information with you.

- Bill your retail charges for drugs.
- Drug units billed must match the drug units of the national code definition (HCPCS or CPT) – not the NDC unit definition.
- The NDC number is only needed when the miscellaneous "J" code is billed. Miscellaneous codes suspend to BCBSNC Medical Review for individual consideration. Medical Review will use the average wholesale price (AWP) for the specific NDC number, subject to provider contract discounts.
- Drug units used can now be billed up to seven units on a claim line. If greater than seven units, then the drug must be split-billed for electronically submitted claims, with no claim line having more than seven units.
- BCBSNC uses a national vendor to determine base AWPs. Applicable provider contract discounts will be applied to base AWPs to process claims. AWP methodology is as follows:
  - For a single-source drug or biological, the AWP equals the AWP of the single-source product.
  - For a multi-source drug or biological, the AWP is equal to the lesser of the median AWP of all the generic forms of the drug or biological or the lowest brand-name product of the AWP. A "brand-name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.
  - AWPs will be adjusted (up or down) four times a year based on national vendor data.
  - To obtain specific fee schedule information related to your contract, please contact your Network Management representative.
- Home infusion prescription drugs and solutions may be infused via one of these routes: intravenous, intraspinal, epidural or subcutaneous. Other medications eligible for reimbursement by a home infusion therapy provider include injections administered during the same visit as the infusion therapy and requiring administration by a health care provider such as a RN or LPN.

2005 Federal Employee Program Service Benefit Plan – Comparison of Benefits

Benefit	2005 Standard Option PPO	2005 Basic Option
REFERRALS	**Not Required**	**Not Required**
PHYSICIAN CARE ◉ Diagnostic & treatment services provided in the office	**PPO:** $15/office visit, 10%* of our allowance **Non-PPO:** 25%* of our allowance	**PPO:** $20/office visit for primary care physicians $30/office visit for specialists No copayment for lab and X-rays **Non-PPO:** Member pays all charges
HOSPITAL CARE ◉ Inpatient	**PPO:** $100 per admission **Non-PPO:** $300 per admission	**PPO:** $100 per day up to $500 admission **Non-PPO:** Member pays all charges
◉ Outpatient	**PPO:** 10%* of our allowance (no deductible for surgery) **Non-PPO:** 25%* of our allowance (no deductible for surgery)	**PPO:** $40 per day per facility **Non-PPO:** Member pays all charges
EMERGENCY CARE ◉ Accidental Injury	**PPO:** Nothing for outpatient hospital & physician services within 72 hours; regular benefits thereafter **Non-PPO:** Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter	**PPO:** $50 copayment for emergency room care; $30 copayment for urgent care **Non-PPO:** $50 copayment for emergency room care
◉ Medical Emergency	Regular benefits	Same as for accidental injury
PRESECRIPTION DRUGS	Retail Pharmacy **PPO:** 25% of our allowance up to a 90-day supply **Non-PPO:** 45% Average Wholesale Price (AWP) allowance up to a 90-day supply **Mail Order:** $10 generic/$35 brand-name per prescription up to a 90-day supply	Retail Pharmacy **PPO:** $10 for generic/$25 for formulary brand-name drugs/50% coinsurance ($35 minimum) for non-formulary brand-name drugs. 34-day maximum supply on initial prescription; up to 90 days for refills with three copayments **Non-PPO:** Member pays all charges **Mail Order:** No Benefit

(Continued on page 15)

2005 Federal Employee Program Service Benefit Plan – Comparison of Benefits (continued from p.14)

Benefit	2005 Standard Option PPO	2005 Basic Option
REFERRALS	**Not Required**	**Not Required**
DENTAL CARE	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	**PPO:** $20 copayment for 2 exams, X-rays, cleanings pre year, and sealants for children up to age 16 $20 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery **Non-PPO:** Member pays all charges
CHIROPRACTIC CARE	**No Benefit**	**PPO:** $20 copayment; up to 20 spinal manipulations per year **Non-PPO:** Member pays all charges
MENTAL HEALTH AND SUBSTANCE ABUSE CARE**	**PPO:** $15 office visit copayment; $100 per admission **Non-PPO:** Benefits are limited	**PPO:** $20 office visit copayment; $100 per day up to $500 per admission (prior approval required) **Non-PPO:** Member pays all charges
PROTECTION AGAINST CATASTROPHIC COSTS (Member's out-of-pocket maximum)	Nothing after $4,000 (PPO) or $6000 (combined PPO/Non-PPO) per contract per year; some costs do not count towards this protection	Nothing after $5000 (PPO) per contract per year; some costs do not count towards this protection

*Is subject to the calendar year deductible: $250 per person or $500 per family for 2005 Standard Option; no deductible for 2005 Basic Option. If member uses a non-PPO physician or other health care professional under Standard Option, they will generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown in the table above. Basic Option does not provide benefits when member uses non-PPO providers.

Treatment plans are required prior to the 9th visit under Standard Option. Under Basic Option, member **MUST call their local Blue Cross and Blue Shield Plan mental health and substance abuse assistance number on the back of their ID card for prior approval before the first visit for mental health and substance abuse services.

DO NOT RELY ON THIS CHART ALONE. This is only a summary of the features of the Blue Cross and Blue Shield Service Benefit Plan. Before making a final decision, please read the plan's federal brochure (RI-71-005). All benefits are subject to the definition, limitations and exclusions set forth in the federal brochure. For a contractual and complete description of the benefits available under the Service Benefit Plan, please refer to the 2005 *Blue Cross and Blue Shield Service Benefit Plan Brochure*.

BlueCross® BlueShield®
Federal Employee Program

BlueCross BlueShield of North Carolina

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Ancillary Credentialing

Blue Cross and Blue Shield of North Carolina (BCBSNC) is no longer issuing provider numbers to nonparticipating ancillary providers. If a nonparticipating ancillary provider needs to file a claim with BCBSNC, simply write "nonparticipating" on the claim form in the box indicated for provider name/address information. However, if you are an ancillary provider who already has a BCBSNC provider number, you can continue to use the number when submitting claims to us. Payment will be sent to the BCBSNC member if you are a nonparticipating provider.

If an ancillary provider wants to become a participating provider, please go to our Web site at ***bcbsnc.com*** and click on the "I'm A Provider" home page. Then, select "Apply For Credentialing Instructions," and choose your specialty from the list. You will see the credentialing requirements and a link to use to download the application. Once you complete the application, submit it and supporting documents directly to the BCBSNC Credentialing Department.

After the BCBSNC Credentialing Committee has approved your application, our Network Management Department will send you a contract to sign to become a participating provider in our ancillary provider network.

BlueCross BlueShield of North Carolina

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