Evidence-based Steps for Increasing Chlamydia Screenings at Your Practice

Despite national guidelines recommending routine chlamydia screening for sexually active young women, screening rates remain low nationally and in North Carolina. For BCBSNC female members ages 16 to 25, the 2005 HEDIS chlamydia screening rate was 25.3 percent. This is far lower than rates for all other BCBSNC women’s health services measured by HEDIS, including Pap smears (80.5 percent).

To support practices in efforts to increase chlamydia screening, BCBSNC staff helped facilitate continuous quality improvement (CQI) meetings at three large OB/GYN practices in late 2004. The participating practices were Winston-Salem Womencare, Hawthorne OB/GYN, and Lyndhurst GYN Associates; along with solo practices, Herbert A. Soper, M.D. and Forsyth GYN Associates. The program evaluation found that taking the following key steps caused the average chlamydia screening rate to increase by 138 percent one year after the CQI meetings.

**Key Steps for Increasing Chlamydia Screenings**

- Conduct an initial chart audit to assess your practice’s screening rate. Pull 10 charts from recent visits among women ages 16-25 and determine the number of women who were screened. BCBSNC can also provide screening rate data to practices using claims data.
- Select a physician or nurse champion who will raise this issue at a staff meeting and discuss ways to overcome barriers to chlamydia screening. Facilitate a discussion on how to make chlamydia-screening part of the routine workflow at your practice.
- Develop a policy for routine chlamydia screening at your practice. Communicate the policy to all providers. Set a target for chlamydia screening at your practice.
- Tell doctors, mid-level practitioners, nurses, and staff that chlamydia screening is a covered benefit for most members with commercial insurance or Medicaid.

(continued on page 2)
Credentiaing Made Easier

Blue Cross and Blue Shield of North Carolina (BCBSNC), working with the Council for Affordable Quality Healthcare (CAQH), is committed to streamlining the administrative process for physicians and other health care providers. BCBSNC has been an active participant in CAQH’s efforts to help eliminate the need for physicians and other health care providers to fill out and submit multiple credentialing/recredentialing applications.

Data Source Alleviates Administrative Requirements

The innovative credentialing system works this way – each physician or health care provider will submit just one standard application to a single database that is designed to meet the informational needs of participating health plans. Benefits include:

- Easy online or fax submission of information
- Providers can easily update their information anytime and will be asked quarterly to verify the accuracy of the information on file. In addition, there is a system in place to automatically notify health plans when the health care provider’s information is updated.
- BCBSNC can access the credentialing information anytime as long as the provider has authorized it.

BCBSNC will continue to conduct data verification and review and make an independent decision about whether a provider meets our standards for participation.

There is no cost for physicians and other health care providers to submit information to the credentialing data collection system. The costs associated with developing and maintaining the system is paid for by the participating CAQH health plans. Today, over 300,000 providers nationwide are now reducing paperwork and administrative costs through the Universal Credentialing DataSource.

In developing the system, CAQH worked closely with health plans, providers, professional associations and accreditation organizations to help make the system meet the needs of all involved in the credentialing process. CAQH selected GeoAccess, a leader in health care data management, as its technology partner. GeoAccess collects, maintains and secures all data in its state-of-the-art data center.

To learn more about CAQH and the CAQH Universal Credentialing DataSource, please visit their Web site at CAQH.org, where you can view an online demonstration of the system and register to begin utilizing this service.

Evidence-based Steps for Increasing Chlamydia Screenings at Your Practice

(continued from page 2)

- Place chlamydia specimen collection materials next to Pap test collection kits in exam rooms.
- Recommend chlamydia screening to all young women during routine Pap smears.
- Make copies of free chlamydia education materials that can be given to patients.
- Conduct a chart review 6-8 weeks following the implementation of workflow changes to assess progress with efforts. Keep making improvements until your practice reaches the goal.

Congratulations to the practices that participated in the 2004 CQI meetings for their hard work on maintaining a high screening rate. One year after implementing the steps described above, the average chlamydia-screening rate among these practices was 53 percent, compared to an average screening rate of 22 percent among three comparison practices.

For more information about this program or to request assistance with increasing chlamydia screening at your practice, please contact us at quality@bcbsnc.com or 1-800-811-8324. Free Chlamydia Screening Provider Toolkit materials are also available upon request.

Free patient education handouts can be printed and copied from the following sources:

- The Centers for Disease Control and Prevention has a two-page information sheet in English and Spanish available at cdc.gov/std/chlamydia/STDFact-Chlamydia.htm.
- The Chlamydia Care Quality Improvement Toolbox, developed by the California Chlamydia Action Coalition, has a two-page patient education fact sheet in English and Spanish available at ucsf.edu/castd/toolbox/.

1 Applicable copayments, coinsurance or deductibles will apply.
According to a recent article featured in *Medical Economics* titled “The Art and Science of the Clean Claim,” submitting error-laden claims leads directly to claims denials. Reworking one denied claim consumes approximately $25 worth of staff time¹.

Even though your practice is most likely over-burdened with administrative work, cleaning up your claims submission process is not only a good practice, but also a necessary one.

RealMed, an all-in-one revenue cycle management solution, allows practices to submit all claims to payers through a Web-based, HIPAA-compliant system. Here are just two of the ways that RealMed can help your practice submit cleaner claims:

- **Verify Insurance Coverage/Perform Eligibility Checks in Advance**
  
  When eligibility information is correct, your practice can accurately bill both the payer and the patient, and eliminate up to 60 percent of the causes of claim denials. You will increase your cash flow and decrease days in accounts receivable.

  With RealMed, you can confirm patient eligibility either individually or through unlimited-size batch files. This confirmation can even take place prior to the patient’s appointment, and will highlight potential problems for your review and correction. Eligibility and benefit results are displayed in a consistent, easy-to-understand format for most payers.

- **Manage Payer Edits/Errors**
  
  Even the best front-end practices cannot put an end to all claim denials. However, RealMed can help your practice save valuable time and resources with the reworking/resubmittal process.

  RealMed instantly applies the edits you designate to claims before they go to the payer, including basic content validation, CCI, HIPAA, clearinghouse, payer-specific and custom edits. Easily understandable error messages are instantly returned, which highlight the problem with the claim, and give you a clear explanation of what is wrong and how to fix it. With RealMed, you can correct and resubmit claims with only a few clicks of your mouse, which greatly reduces follow-up calls and other work typically required to fix denied claims.

Additionally, RealMed offers a variety of other tools that may help your practice maximize its revenues and positively affect your administrative efficiency, including:

- Claims Status Management
- Remittance Management
- Reporting Capabilities
- Patient Statement Management

If you have questions or would like to discuss how RealMed can help your practice, contact Jeff Dolan with Real Med at 919-806-4405, or visit realmed.com.

New Medicare Advantage Fee-For-Service Plan

“Medicare Advantage” is the new program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as “traditional Medicare”). It offers Medicare beneficiaries several product options, including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans. Several Blue Plans offer Medicare Advantage products, so you may be seeing out-of-area Medicare Advantage members.

What is Medicare Advantage Private Fee-For-Service? A Medicare Advantage PFFS plan is a plan offered by an organization that pays physicians and providers on a fee-for-service basis. There is no specific network that providers sign up for to service PFFS patients. Patients can obtain services from any licensed physician or provider in the United States who is qualified to be paid by Medicare and accepts the plan’s terms of payment. The plan must provide the same coverage as Medicare Part A and Part B, but may offer additional services.

How will you recognize Medicare Advantage PFFS members? Just ask for the member’s ID card, which will have a Blue Cross and/or Blue Shield logo on it. Members will not have a standard Medicare card. Look for this logo:

 Verify member eligibility by calling 1-800-676-BLUE (2583) or electronically via Blue eSM. Be sure to verify if Medicare Advantage benefits apply. Submit claims for Medicare Advantage PFFS members to BCBSNC. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a Blue Plan. Providers can collect any applicable cost-sharing amount, such as copayment or deductible, from the member at the time of service.

Quick Tips for a Smooth Out-of-Area Claims Experience

At BCBSNC we strive to process claims quickly and accurately. Did you know that you can make a difference in how quickly claims are processed? Following these helpful tips will improve your claims experience:

* Check eligibility and benefits electronically on Blue e or by calling 1-800-676-BLUE (2583). Be sure to provide the member’s alpha prefix.
* Verify the member’s cost-sharing amount before processing payment.
* Indicate on the claim any payment you collected from the patient. (For the 837 electronic claim format, use qualifier F6, Patient Paid Amount, and include the amount in the AMT01 segment; on the CMS1500 locator 29 amount paid; on UB92 locator 54 prior payment; on UB04 locator 53 prior payment.)
* Submit all Blue claims to BCBSNC. Be sure to include the member’s complete identification number when you submit the claim. This includes the three-character alpha prefix. Submit claims with only valid alpha-prefixes. Claims with incorrect or missing alpha prefixes and member identification numbers cannot be filed correctly.
* In cases where there is more than one payer and a Blue Cross and/or Blue Shield Plan is a primary payer, submit other party liability information with the Blue Cross and/or Blue Shield claim. Upon receipt, BCBSNC will electronically route the claim to the member's Blue Plan. The member’s Plan will process the claim for payment, and eligible reimbursement will be made to you by BCBSNC.
* Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
* Check claim status by contacting BCBSNC at 1-800-487-5522 or from your desktop by submitting an electronic HIPAA 276 transaction (claim status request) on Blue e.

Additional information about the BlueCard program and claims filing for Blue Plan members can be located in your 2006/2007 BCBSNC Provider Manual.

Verifying Blue Member Eligibility on Blue e Just Got Easier

At BCBSNC, we understand you need the right tools and resources to provide the best care to Blue Plan members. So to help you obtain member eligibility more quickly, we have enhanced our Blue e electronic services. For BCBSNC members, you can submit eligibility requests electronically and receive real-time responses to your eligibility requests. For out-of-area Blue Plan members, you can receive responses to your eligibility requests in less than a minute. Out-of-Area Blue Plans are now required to respond to these inquiries within 50 seconds.

We’ve also extended our service hours for you. We can process your electronic eligibility requests Monday through Saturday, from 4:00 a.m. to midnight Central Time. In
addition to receiving eligibility verifications electronically via Blue e, you can always call the BlueCard Eligibility Line at 1-800-676-BLUE (2583).

Your satisfaction is very important to us, and we are committed to improving our service to you. In the coming year, you will see several additional enhancements in the electronic services arena, including the availability of more detailed eligibility information for Blue Plan members.

**BCBSNC Continues to Improve Services to Providers**

At BCBSNC, provider satisfaction is our top priority. We highly value the care you provide to all Blue Plan members, and we constantly strive to improve our processes in order to serve you more effectively and efficiently. Here are just a few of the ways in which we've implemented your suggestions:

- **We've improved our claim timelines for out-of-area claims.** Providers were more satisfied with claim timelines for out-of-area claims in 2005 as compared to previous years. In 2006, you will continue seeing improvements, as Blue Plans around the country are working together to further improve claim payment timelines for out-of-area claims.

- **We've improved claim accuracy for out-of-area claims.** Providers were more satisfied with claim accuracy for out-of-area claims in 2005 as compared to previous years. The number of claims requiring follow-up decreased significantly over the last two years. In 2006, you will continue seeing improvements as Blue Plans around the country are working together to further improve claim payment procedures.

- To enhance electronic eligibility services for local out-of-area Blue Plan members in real time, we've improved our electronic services.

- **You can obtain real-time eligibility verifications electronically via Blue e** for BCBSNC members, and for out-of-area members, you can obtain eligibility verifications electronically in less than a minute.

- **Blue Plans around the country have extended their service hours**, so you can receive near real-time responses.

In addition, you will see enhancements in service for your out-of-area members, including:

- Improved claim payment timeliness
- Improved claim accuracy
- Reduced number of claims requiring follow-up
- Streamlined medical records requests

To continue evaluating our performance, we want to hear from you. Throughout the year, we will be conducting provider surveys to measure your satisfaction with the BlueCard Program. If you receive a call, please take a moment to participate, as your feedback is very important to us.

**BCBSNC Needs Your Help With Verifying Provider Data**

More than 784,000 BlueCard Program members currently reside in North Carolina. BCBSNC’s ability to successfully direct Blue Plan members to you depends on the accuracy of the information that you provide us about you and your facility.

To keep information about our network providers up-to-date and accurate, a vendor will contact a randomly selected list of providers each quarter to verify some of the following information:

- Provider’s name
- Provider’s specialty
- Provider’s address
- Telephone number for scheduling an office visit

(The company will verify this information with your front office staff.)

In order to ensure that your contact information is up-to-date with us, please advise your front office staff to maintain an updated provider roster and be prepared to provide accurate responses. It’s very important that you notify BCBSNC when you move or change your information.

It is important that your information is shared with Blue Plan members. Many members use bcbsnc.com to find a participating provider. We encourage you to occasionally check the BCBSNC online directory to ensure that your information is accurate.

Thank you in advance for your cooperation.

**BlueCard Fund Distribution Program Launched in July**

In certain circumstances, providers return money to BCBSNC for BlueCard Host members for previous claim activity. The main reasons this occurs is due to:

- Refunds due to Coordination of Benefits
- Overpayments
- Provider Audit Recoveries

When these dollars are received, BCBSNC is obligated to refund the money to the Home Plan. There are times when dollars cannot be credited back to Home Plans on a specific claim basis due to various reasons. These dollars are held in a special account and must still be returned to Home Plans. BCBSNC launched a program to distribute the funds back to Home Plans this July.
Working in conjunction with the Home Plans, the BCBS payment you receive will be made up of a combination of money from the Home Plan and money from this special account. This is all done behind the scenes and you will receive payment as you always do. However, due to the complex coordination of payment between the Home Plan and BCBSNC you may occasionally see very small reimbursements (in cases where the member has not met their deductible) paid by BCBSNC.

If you have additional questions about this program, please contact your BCBSNC Network Management representative.

Provider-Initiated Refunds for Out-of-Area Members

As mentioned in the article on page 3 of this issue, “RealMed Helps You Clean Up Your Claims,” reworking one denied claim can costs as much as $25 dollars in administrative staff time. This cost potentially increases when the claim is for out-of-area Blue Plan members, as both BCBSNC and the member's Home Plan are involved in the transaction. Because of this coordination with other Blue Plans, it is critical that we receive accurate information whenever you send us a refund for these members.

So that we can effectively represent your interest when contacting the Home Plan about a provider-initiated refund, we need sufficient documentation to link a particular refund to a specific claim. When sending provider-initiated refunds to BCBSNC, please use the following checklist to help ensure that all necessary information is provided:

1. Ensure that the amount being returned does not exceed the amount paid for the original claim.

2. Provide Explanation of Benefits (EOB) documentation for any insurance carrier associated with the claim for which a refund is being provided. Ensure that the EOB documentation includes:
   - Provider's name
   - Provider's BCBSNC ID number
   - Policyholder's full name
   - Policyholder's ID (include prefix and number)
   - Patient's full name
   - Patient's date of birth
   - Original claim number
   - Date of service
   - Amount of charge for the original claim
   - Amount paid for the original claim
   - Date of payment for the original claim
   - Amount being returned against the original charge

3. Provide one of the following specific reasons for the refund:
   - Duplicate payment (requires both BCBSNC vouchers)
   - Worker’s Compensation (provide the date of onset)
   - Medicare payment is primary (need EOB)
   - Other carrier paid primary (need EOB)
   - Corrected claim / billed in error (need EOB)
   - Filed under wrong patient (need copy of claim)
   - Incorrect date of service (need corrected claim)
   - Medicare adjusted payment (need EOB)
   - Other carrier adjusted payment (need EOB)
   - Not your patient

4. When applicable, provide a corrected claim form.

5. Supporting documentation must include:
   - Copy of the original claim
   - Original Notification of Payment (NOP)
   - If sending a refund as a rebuttal to a payment issue previously discussed with BCBSNC, please attach a copy of the information described above, as well as a copy of the BCBSNC check voucher to the check.

Organizing and providing this information will allow BCBSNC to process your initiated refund more efficiently and accurately. Refund checks received without the necessary support information will be returned to the provider.

To further assist you, BCBSNC has created the Host Plan Provider-Initiated Refund Form, which can be attached to every provider-initiated refund and used as a checklist to help ensure that all necessary information is provided. A copy of this form is available on the “I’m a Provider” page of our Web site at bcbsnc.com.

Provider-initiated refunds for out-of-area members should be sent to:

Blue Cross and Blue Shield of North Carolina
Attn: Cashiers Department
P.O. Box 30048
Durham, NC 27702-3048

(continued on page 7)
How to Identify BlueCard (Out-of-Area) Plan Members

There’s an easy way to identify out-of-area members through BlueCard. When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership ID card. The main identifier for out-of-area members is the alpha prefix. BlueCard Plan members have a three-character alpha prefix at the beginning of their ID number. The alpha prefix is key to facilitating prompt payments. The member ID is a combination of alpha and numeric characters.

**Note:** Do not assume that the member’s ID number is the Social Security number. Use of the Social Security number on ID cards was generally phased out by the end of 2005.

Once you find the alpha prefix, you should call the BlueCard Eligibility Line at 1-800-676-BLUE (2583) to verify the patient’s membership and coverage. For faster processing, you can use Blue e.

In addition, the ID cards may have logos that appear on the front of Blue Plan member ID cards, such as:
- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo

When you see these logos, it means that the cardholder participates in the BlueCard Program, which provides health care coverage for members outside of their Home Blue Plan area. When either the blank suitcase or “PPO in a suitcase” logo appears on a Blue Plan member ID card, you should submit the claim(s) to BCBSNC. You may also see ID cards without a suitcase logo from other Blue National Account members. Submit these claims to BCBSNC too.

Three-character alpha prefix

The “suitcase” logo may appear anywhere on the front of the card.
State Health Plan: Updates and Reminders

State Health Plan Offers New PPO Products to Employees

The State Health Plan is now offering their employees a choice of three Blue Options SM PPO products to be effective October 1, 2006. Under the banner of NC SmartChoice, the three plans are NC SmartChoice Basic, NC SmartChoice, and NC SmartChoice Plus, and vary relative to the members' out-of-pocket costs under each plan.

The State PPO product will follow all of the requirements of a BCBSNC PPO plan. We encourage you to learn about the specifications of the new State PPO health plan and how this affects your operations. Remember to check the State Health Plan member's ID card to verify what plan the member is enrolled in.

BCBSNC will begin accepting precertification requests August 1, 2006, for services to be performed on or after October 1, 2006. Precertification is required for all procedures and services on the Blue Options Prior Plan Approval (PPA) list. If you do not obtain precertification for these services, the claim will be denied, as it would be for other BCBSNC Blue Options plans. You will need to supply clinical information along with the request for precertification of PPA procedures.

Mental Health/Substance Abuse services will be administered through Value Options, not Magellan Behavioral Health. Status One will administer the case management services. State PPO members will not be eligible for Member Health Partnerships SM programs through BCBSNC. The State Health Plan has contracted directly with Health Dialog to provide disease management programs.

Remember that the new State Health Plan Blue Options PPO products do not go into effect until October 1, 2006. Except where PPO is specifically listed, all other State Health Plan information contained in this publication is meant for currently active State Health Plan and NC Health Choice membership only.

Watch for more detailed information about the new State PPO plans in the next issue of Blue Link.

Maternity and Newborn Inpatient Benefits

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

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

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

Multiple Surgical Procedures

The State Health Plan pays for a surgeon’s services differently when two or more surgical procedures are performed at the same time.

Multiple surgical procedures performed through separate incisions or approaches are paid at 100 percent of UCR for the surgical procedure that has the higher UCR allowance and at 50 percent of UCR for the remaining procedure(s).

Multiple surgical procedures performed through the same incision or approach are paid based on the procedure that has the higher UCR.

Courtesy Review vs. Appeals

If a provider disagrees with the way the State Health Plan processed a claim, contact State Health Plan Customer Services and request a “courtesy review.” This review can be done without the member's authorization. The State Health Plan Customer Services Department can resolve most problems and concerns without the member having to use the formal appeals process.

(Continued on page 9)
State Health Plan: Updates and Reminders (continued from page 8)

Only a member can initiate the appeals process. Before a third party, including the provider, can submit an appeal on the member’s behalf, we must have a State Health Plan approved authorization form signed by the member. The information on the form must specify the exact dates and service to be appealed. When medical records are requested, send the records to the appeals analyst who requested them within the specified time frame. Failure to submit records timely will result in the continuation of the denial.

Prior Approvals

When the State Health Plan receives a request for prior approval, our goal is to make a decision within three business days, and no more than seven days from the time we have all the necessary clinical information. All approvals are sent to the provider via fax. In the absence of a fax number, a phone call is placed to the provider. If the approval is denied, a letter and a fax are sent to the provider. If your cover sheet lists more than one location, please circle the fax number that the approval should be sent to.

In order for a claim to be considered for retrospective review, the request must be received within six months (180 days) of the end date of service. Request received after the 180 days of the end date of service will be denied. Prior approval forms can be obtained from the State Health Plan Web site at statehealthplan.state.nc.us.

BCBSNC Names Cardiac Centers of Excellence

Blue Cross and Blue Shield of North Carolina (BCBSNC) has selected 17 cardiac facilities and designated them as Cardiac Centers of Excellence. The designation is part of the national Blue Cross and Blue Shield Association’s (BCBSA) Blue Centers for Cardiac Care program. These facilities were all identified as meeting strict nationally recognized criteria for experience, quality and efficiency. The designation is intended to inform heart patients about doctors and hospitals that have a proven track record of patient safety and delivering favorable outcomes.

“The Cardiac Centers of Excellence program is just another example of how Blue Cross and Blue Shield of North Carolina is committed to working together with doctors and hospitals to increase quality and improve patient safety,” said Dr. Robert T. Harris, BCBSNC chief medical officer. “This program is one way to identify facilities across North Carolina that utilize evidence-based medicine and proven treatment methods to reduce complications often associated with heart surgery.”

The 17 Cardiac Centers of Excellence are full-service, fully accredited facilities that perform at least 100 open-heart surgeries each year. They were evaluated based on criteria developed through a collaboration of expert physician panels and national organizations. Those criteria focus on experience, commitment to quality and rate of favorable outcomes. They are the same standards used by a similar nationwide program launched in conjunction with the Blue Cross and Blue Shield Association.

BCBSNC members will have a variety of ways to identify Cardiac Centers of Excellence: self-promotion by the Center, physician referral, and online at bcbsnc.com. Members can also find Cardiac Centers of Excellence included in a state-by-state listing on bcbs.com or by calling 1-800-810-BLUE (2583).

Cardiac Centers of Excellence

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<tr>
<td>Cape Fear Valley Medical Center, Fayetteville</td>
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<td>Carolinas Medical Center, Charlotte</td>
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<td>Craven Regional Medical Center, New Bern</td>
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<td>Duke University Hospital, Durham</td>
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<td>Forsyth Medical Center, Winston-Salem</td>
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<td>Frye Regional Medical Center, Hickory</td>
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<td>Gaston Memorial Hospital, Gastonia</td>
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<td>High Point Regional Hospital, High Point</td>
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<td>FirstHealth Moore Regional Hospital, Pinehurst</td>
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<td>Moses H. Cone Memorial Hospital, Greensboro</td>
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<td>North Carolina Baptist Hospital, Winston-Salem</td>
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<td>Northeast Medical Center, Concord</td>
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<td>Rex Hospital, Raleigh</td>
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<td>UNC Hospitals, Chapel Hill</td>
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<td>WakeMed Raleigh Campus, Raleigh</td>
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Rx Corner

Specialty Pharmacy Network Changes Effective July 1, 2006

In order to continue to provide our participating providers with a convenient, simplified alternative for obtaining specialty pharmacy drugs for BCBSNC members, we have made changes to our specialty pharmacy program. As a participating physician, when you need to order a specialty pharmacy drug, simply contact a participating specialty pharmacy vendor, order the drug, and the drug will be shipped directly to your office (usually within 24-48 hours) after the specialty pharmacy provider confirms member eligibility and benefits. The specialty pharmacy provider, not you, will bill BCBSNC for the drug.

Effective July 1, 2006, the list of specialty pharmacy drugs available through a participating specialty pharmacy vendor was expanded, allowing access to more specialty pharmacy drugs without the need for you to incur financial liability. In addition, Caremark, Inc. and McKesson Specialty will become our sole participating specialty pharmacy providers. To reach one of our specialty pharmacy vendors, please call them at:

<table>
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<tr>
<th>Caremark, Inc.</th>
<th>McKesson Specialty</th>
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<tr>
<td>1-800-571-3922</td>
<td>1-888-456-7274</td>
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While the use of a specialty pharmacy vendor is voluntary, please keep in mind that you can save time and eliminate financial liability by ordering from a participating specialty pharmacy vendor, as they will bill BCBSNC directly.

Please refer to the provider section of our Web site at bcbsnc.com for the most current information regarding our specialty pharmacy network including a list of available drugs and additional ordering information.

Please note that these changes exclude the State of North Carolina Teachers’ and State Employees’ Comprehensive Major Medical Plan (State Health Plan) and NC Health Choice for Children.

Copayment Waiver Extended for Generic Rx Drugs

Blue Cross and Blue Shield of North Carolina’s (BCBSNC’s) generic copayment waiver program, which began on February 1, 2006, is extended through December 31, 2006.

BCBSNC members can take advantage of this cost-saving initiative by presenting a prescription for a generic drug to a participating BCBSNC pharmacy. The copayment, or any applicable coinsurance costs, will automatically be waived when the prescription is filled. Please note that any prescription drug deductible must be met before the member is eligible for the waiver.

BCBSNC members may continue to choose higher-cost brand-name drugs even when generic alternatives are available or authorized by their doctor. However, BCBSNC is encouraging members to discuss prescription drug options with their physicians and decide together if a generic drug might be an appropriate alternative to a brand-name choice.

The 2006 generic copayment waiver program is open to members of fully insured and self-funded employer groups purchasing pharmacy benefits from BCBSNC. For eligible groups with BCBSNC members living out-of-state, this program will still apply if they go to a participating Medco pharmacy and choose a generic drug.

Formulary Reminder: Self-administered Drugs

BCBSNC will update the list of self-administered medications excluded from the medical benefit at least annually. Please refer to our Web site under “Find a Drug” for the most current listing of these excluded drugs.

(continued on page 11)
New Generics

The following drug products have recently become available as generic products, and are available at the lowest copayment level, Tier 1, on the BCBSNC commercial and Medicare Part D Plus formularies. Reassure your patients that the U. S. Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity and stability as brand-name drugs. Save money for your patients and prescribe generic drug products when appropriate.

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<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Therapeutic Class</th>
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<tbody>
<tr>
<td>Copegus</td>
<td>Ribavirin tablet</td>
<td>Miscellaneous Antivirals</td>
</tr>
<tr>
<td>Sandostatin</td>
<td>Octreotide acetate injection</td>
<td>Miscellaneous Antineoplastic Drugs</td>
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<tr>
<td>Darvocet A500</td>
<td>Propoxyphene napsylate 100 mg / acetaminophen 500 mg</td>
<td>Propoxyphene</td>
</tr>
<tr>
<td>*Xanax XR</td>
<td>Alprazolam extended-release</td>
<td>Anxiolytics</td>
</tr>
<tr>
<td>DynaCirc</td>
<td>Isradipine</td>
<td>Calcium Channel Blockers - Dihydropyridines</td>
</tr>
<tr>
<td>Flonase</td>
<td>Fluticasone propionate nasal spray</td>
<td>Intranasal Steroids</td>
</tr>
<tr>
<td>Terazol 3</td>
<td>Terconazole vaginal suppository</td>
<td>Vaginal Antifungals</td>
</tr>
<tr>
<td>MetroGel Vaginal</td>
<td>Metronidazole vaginal gel</td>
<td>Vaginal Anti-Infective</td>
</tr>
<tr>
<td>Didronel</td>
<td>Etidronate disodium</td>
<td>Miscellaneous Agents</td>
</tr>
</tbody>
</table>

*Not covered on the Medicare Part D formulary. Benzodiazepines are excluded from Part D coverage by CMS.

Commercial Drug Formulary Update

The following drug product has been added to Tier 2 of BCBSNC’s commercial formulary.

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Niaspan</td>
<td>Niacin extended-release</td>
<td>Lipid / Cholesterol Lowering Agents</td>
</tr>
</tbody>
</table>

Do You Have Your National Provider Identifier Yet?

Are you ready? May 23, 2007, is rapidly approaching. That’s the date when a national provider identifier (NPI), a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), will be required for all standard electronic transactions. All health care providers (individuals, facilities, organizations, suppliers, etc.) are encouraged to obtain an NPI. For more information about the NPI, including application procedures, please contact https://nppes.cms.hhs.gov. The national versions of both the professional (CMS1500) and institutional (UB-04) claim forms have been revised to allow filing paper claims with an NPI to identify the health care provider.

Blue Cross and Blue Shield of North Carolina (BCBSNC) is collecting NPIs through its online provider portal, Blue e (if you are currently an authorized user) or by mail. Please apply for your NPI and register it with BCBSNC when you receive it. Please note that electronically submitted claims will only be accepted using the BCBSNC provider number through May 22, 2007. BCBSNC will send notification through Blue e when claims can be accepted using only an NPI.

(continued on page 12)
As part of BCBSNC’s NPI collection methods, providers will have the option to submit both the group and its associated individual providers’ NPIs. As a reminder, there are two types of NPI numbers that are assigned via the Centers for Medicare and Medicaid Services (CMS) – the developed enumeration system and the National Plan and Provider Enumeration System:

- **Type 1:** Assigned to an individual who renders health care services that may include physicians, nurses, physical therapists and dentists.

- **Type 2:** Assigned to a health care organization and its subparts that may include hospitals, skilled nursing facilities, home health agencies, pharmacies and suppliers of medical equipment (durable medical equipment, orthotics, prosthetics, etc).

It is important to evaluate your business/organization and associated relationships (vendors, clearinghouses, health plans, etc.) prior to applying for an NPI. The NPI will replace all carrier provider identifiers including those used for Medicare, Medicaid, BCBSNC and other health insurers. However, it will not replace current BCBSNC policies and procedures for credentialing and provider participation. Therefore, depending on your type of business, it is your responsibility to determine how many NPIs are needed in order to continue current business functions.

The following Web sites are available to you for further information about NPI, the enumeration system and industry recommendations:

- **NPI Overview and Application Process:**
  [cms.hhs.gov/MedlearnNetworkGenInfo](https://cms.hhs.gov/MedlearnNetworkGenInfo)

- **Enumeration System:**
  [nppes.cms.hhs.gov/NPPES](https://nppes.cms.hhs.gov/NPPES)

- **Industry Recommendations and White Papers:**
  [www.wedi.org](http://www.wedi.org)

Is your billing service, clearinghouse, and/or practice software manager ready? If not, here are some suggested questions to ask your practice management vendor, clearinghouse, or billing service:

- Are you aware of NPI?
- Have you started internal discussions about how your company will implement the NPI requirements?
- Do you plan to build a crosswalk from the current provider ID numbers to the NPI numbers prior to May 2007?
- Where will you obtain/accept provider’s NPI(s)? (Examples: from provider; CMS; other)
- When do you plan to accept only NPI(s) from providers?
- Will you have the capability to file both the current provider ID number and the NPI?
In conjunction with our Physician Advisory Group, and based on NCQA requirements, BCBSNC has established medical records standards to encourage the quality and appropriateness of physician documentation in office medical records. Medical record reviews are conducted at least every three years on all primary care and OB/GYN physicians to assess compliance with the standards.

The only change for 2006 is in the wording of standard number nine (9) dealing with documentation of smoking, ETOH and substance abuse. That standard has been changed to clarify requirements that all three aspects of the documentation must be present for credit to be given for the indicator.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All pages contain patient identification.</td>
<td>1. Each page in the medical record must contain the patient’s name or ID number.</td>
</tr>
<tr>
<td>2. Each record contains biographical/ personal data.</td>
<td>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.</td>
</tr>
<tr>
<td>3. The provider is identified on each entry.</td>
<td>Each entry in the medical record must contain author identification (signature or initials).</td>
</tr>
<tr>
<td>4. All entries are dated.</td>
<td>Each entry in the medical record must include the date (month, day and year).</td>
</tr>
<tr>
<td>5. The record is legible.</td>
<td>The medical record must be legible to someone other than the writer.</td>
</tr>
<tr>
<td>6. There is a completed problem list.</td>
<td>The flow sheet includes age-appropriate preventive health services. A BLANK PROBLEM LIST OR FLOW SHEET DOES NOT MEET THIS STANDARD.</td>
</tr>
<tr>
<td>7. Allergies and adverse reactions to medications are prominently displayed.</td>
<td>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.</td>
</tr>
<tr>
<td>8. The record contains an appropriate past medical history.</td>
<td>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 illness. The medical history should be updated periodically.</td>
</tr>
<tr>
<td>9. Documentation of smoking habits, alcohol use and substance abuse is noted in the record.</td>
<td>The medical record should reflect the use of or abstention from smoking (cigarettes, cigars, pipes and 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.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>10.</td>
<td>The record includes a history and physical exam for presenting complaints.</td>
</tr>
<tr>
<td>11.</td>
<td>Lab and other diagnostic studies are ordered as appropriate.</td>
</tr>
<tr>
<td>12.</td>
<td>The working diagnoses are consistent with the diagnostic findings.</td>
</tr>
<tr>
<td>13.</td>
<td>Plans of action/treatments are consistent with the diagnosis(es).</td>
</tr>
<tr>
<td>14.</td>
<td>Each encounter includes a date for a return visit or other follow-up plan.</td>
</tr>
<tr>
<td>15.</td>
<td>Problems from previous visits are addressed.</td>
</tr>
<tr>
<td>16.</td>
<td>Appropriate use of consultant services is documented.</td>
</tr>
<tr>
<td>17.</td>
<td>Continuity and coordination of care between primary and specialty physicians or agency documented.</td>
</tr>
<tr>
<td>18.</td>
<td>Consultant summaries, lab and imaging study results reflect review by the primary care physician.</td>
</tr>
<tr>
<td>19.</td>
<td>Care is demonstrated to be medically appropriate.</td>
</tr>
<tr>
<td>20.</td>
<td>A complete immunization record is included in the chart.</td>
</tr>
<tr>
<td>21.</td>
<td>Appropriate use of preventive services is documented.</td>
</tr>
<tr>
<td>22.</td>
<td>Charts are maintained in an organized format.</td>
</tr>
</tbody>
</table>
23. There is an adequate tracking method in place to insure retrievability of every medical record.

24. Review of chronic medications if appropriate for the presenting symptoms.

Each medical record required for patient visit or requested for review should be readily available. 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.

Routine Depression Screening Recommended for Adults

The U.S. Preventive Services Task Force (USPSTF) recommends that primary care physicians routinely screen adults for depression. Blue Cross and Blue Shield of North Carolina would like to join the USPSTF in encouraging front-line physicians to screen adults. Individuals at increased risk for depression include women, patients with a family history of depression, the unemployed, and those who suffer from a chronic disease.

More than 17 million adults in the United States suffer from major depression. Up to half of major depression cases go undetected, costing the United States $43.7 billion a year in medical expenses and lost productivity. Dysthymia, or minor depression, is equally as common, according to the USPSTF.

Screening Is Vital

Based on a review of randomized trials, the USPSTF found good evidence that screening improves the accurate identification of depressed primary care patients and that treating adults in this setting reduces clinical morbidity.

No screening tool proved more effective than others, and indeed, investigators found that two simple questions may be as effective as longer screening tools. These questions are:

1. “Over the past two weeks, have you ever felt down, depressed or hopeless?”
2. “Over the past two weeks, have you felt little interest or pleasure in doing things?”

Patients who respond positively to these questions should undergo full diagnostic interviews using standard criteria (such as the DSM-IV) to determine whether a specific depressive disorder is present, to gauge the severity of depression, to address any comorbid mental health conditions and to make the appropriate referrals. It is estimated that between 24 percent and 40 percent of patients who screen positive will have major depression. Others may have dysthymia or minor depression.

Treatment Recommendations

The USPSTF recommends that treatment include antidepressant medication or a specific psychotherapeutic technique (for example, cognitive behavioral therapy), either alone or in combination. Psychotherapy probably is as effective as antidepressant treatment, but is more time-intensive. Selective serotonin reuptake inhibitors (SSRIs) perform similarly to tricyclic antidepressants, and both types of antidepressants outperform placebo.

Free Diagnostic Tools Available

We have tools available to assist you in screening your adult patients for depression. Please write to us at partnerships@bcbsnc.com to receive a complimentary set of Zung self-rating depression scales, patient education sheets about anti-depressant medication adherence, depression screening checklists and major depression diagnostic criteria charts for physicians. Let’s work together to help patients overcome the debilitating effects of depression.
New Goals for Cholesterol-Lowering Therapy

Clinical trials published since the release of the Adult Treatment Panel III (ATP III) cholesterol management guidelines have confirmed the benefits of cholesterol-lowering therapy in high-risk patients. The findings support ATP III recommendations for the benefit of LDL-lowering therapy for patients with diabetes and in older persons. New information is also provided about the efficacy of risk reduction in high-risk persons with relatively low LDL-cholesterol (C) levels.

The recommended LDL-C goal for high-risk patients—including those with diabetes as well the elderly—is <100 mg/dL. In very high-risk individuals, an LDL-C goal of <70 mg/dL is reasonable based upon the clinical evidence.

The National Heart, Lung, and Blood Institute offers a cholesterol education tool kit. Visit the NHLBI online at [http://hp2010.nhlbihin.net/cholmonth/chol_kit.htm](http://hp2010.nhlbihin.net/cholmonth/chol_kit.htm), or call 1-301-592-8573 to request the tool kit. A 2006 kit will be available in August.

### ATP III LDL-C Goals and Cutpoints for Therapeutic Lifestyle Changes (TLC) and Drug Therapy in Different Risk Categories and Proposed Modifications Based on Recent Clinical Trial Evidence

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>LDL-C Goal</th>
<th>Initiate TLC</th>
<th>Consider Drug Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk: CHD(^1), or CHD risk equivalents(^2) (10-year risk &gt;20%)</td>
<td>&lt;100 mg/dL (optional goal: &lt;70 mg/dL)(^3)</td>
<td>&gt;100 mg/dL(^3)</td>
<td>&gt;100 mg/dL(^{10}) (&lt;100 mg/dL: consider drug options)(^9)</td>
</tr>
<tr>
<td>Moderately high risk: 2+ risk factors(^4) (10-year risk 10% to 20%)</td>
<td>&lt;130 mg/dL(^7)</td>
<td>&gt;130 mg/dL(^8)</td>
<td>&gt;130 mg/dL (100-129 mg/dL; consider drug options)(^11)</td>
</tr>
<tr>
<td>Moderate risk: 2+ risk factors(^3) (10-year risk &lt;10%)(^4)</td>
<td>&lt;130 mg/dL</td>
<td>&gt;130 mg/dL</td>
<td>&gt;160 mg/dL</td>
</tr>
<tr>
<td>Lower risk: 0-1 risk factor(^5)</td>
<td>&lt;160 mg/dL</td>
<td>&gt;160 mg/dL</td>
<td>&gt;190 mg/dL (160-189 mg/dL; LDL-lowering drug optional)</td>
</tr>
</tbody>
</table>

---

1. Coronary heart disease (CHD) includes history of myocardial infarction, unstable angina, stable angina, coronary artery procedures (angioplasty or bypass surgery), or evidence of clinically significant myocardial ischemia.

2. CHD-risk equivalents include clinical manifestations of noncoronary forms of atherosclerotic disease (peripheral arterial disease, abdominal aortic aneurysm, and carotid artery disease [transient ischemic attacks or stroke of carotid origin or >50% obstruction of a carotid artery]), diabetes, and 2+ risk factors with 10-year risk for hard CHD >20%.

3. Risk factors include cigarette smoking, hypertension (BP >140/90 mm Hg or on antihypertensive medication), low high-density lipoprotein (HDL) cholesterol (<40 mg/dL), family history of premature CHD (CHD in male first-degree relative <55 years of age; CHD in female first-degree relative <65 years of age), and age (men >45 years; women >55 years).


5. Almost all people with zero or one risk factor have a 10-year risk <10%, and 10-year risk assessment in people with zero or one risk factor is thus not necessary.

6. Very high risk favors the optional LDL-C goal of <70 mg/dL, and in patients with high triglycerides, non-HDL-C <100 mg/dL.

7. Optional LDL-C goal <100 mg/dL.

8. Any person at high risk or moderately high risk who has lifestyle-related risk factors (e.g., obesity, physical inactivity, elevated triglyceride, low HDL-C, or metabolic syndrome) is a candidate for therapeutic lifestyle changes to modify these risk factors regardless of LDL-C level.

9. When LDL-lowering drug therapy is employed, it is advised that intensity of therapy be sufficient to achieve at least a 30% to 40% reduction in LDL-C levels.

10. If baseline LDL-C is <100 mg/dL, institution of an LDL-lowering drug is a therapeutic option on the basis of available clinical trial results. If a high-risk person has high triglycerides or low HDL-C, combining a fibrate or nicotinic acid with an LDL-lowering drug can be considered.

11. For moderately high-risk persons, when LDL-C level is 100 to 129 mg/dL, at baseline or on lifestyle therapy, initiation of an LDL-lowering drug to achieve an LDL-C level <100 mg/dL is a therapeutic option on the basis of available clinical trial results.
Uniformed Services Employment and Reemployment Rights Act

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), enacted by the Department of Labor in 1994, with the final rules effective January 18, 2006, most employers are required to allow their employees who commence service in the Uniformed Services to elect to continue insurance coverage under the employer's group health plan for themselves and their covered dependents for up to 24 months.

Generally, USERRA covers an employee who enters the Uniformed Services of the United States of America and serves for no more than five years (cumulative service). The Uniformed Services include the Armed Forces (active and reserve), the Army and Air National Guards, and the commissioned corps of the Public Health Service. USERRA also covers any other category of persons designated by the president in time of war or national emergency.

There are two significant changes affecting health plan coverage in the final January 18, 2006, rules:

- The maximum period of continuation of health plan coverage upon commencement of service in the Uniformed Services changed from 18 to 24 months.
- There are circumstances that allow for retroactive reinstatements of employees performing service in the Uniformed Services for up to 24 months. If the employee did not elect to continue coverage but provided advance notice of service and is absent more than 30 days, the employer must reinstate coverage upon request by the employee and payment of all unpaid premiums. Employers must also reinstate coverage if the employee could not provide advance notice of service due to military necessity.

After 24 months and if an employee remains in the Uniformed Services, coverage ends under the employer's health plan.

Upon return to work, coverage must be reinstated with no new probationary period or pre-existing condition waiting period unless injuries or illnesses are determined by the secretary of Veterans Affairs or his or her representative to be a service-related illness or injury incurred in, or aggravated during, performance of service.

New Goals for Cholesterol-Lowering Therapy

(continued from page 16)

Recommendations for Modifications to Footnote the ATP III Treatment Algorithm for LDL-C

- Therapeutic lifestyle changes (TLC) remain an essential modality in clinical management. TLC has the potential to reduce cardiovascular risk through several mechanisms beyond LDL lowering.
- In high-risk persons, the recommended LDL-C goal is <100 mg/dL.
- An LDL-C goal of <70 mg/dL is a therapeutic option on the basis of available clinical trial evidence, especially for patients at very high risk.
- If LDL-C is >100 mg/dL, an LDL-lowering drug is indicated simultaneously with lifestyle changes.
- If baseline LDL-C is <100 mg/dL, institution of an LDL-lowering drug to achieve an LDL-C level <70 mg/dL is a therapeutic option on the basis of available clinical trial evidence.
- If a high-risk person has high triglycerides or low HDL-C, consideration can be given to combining a fibrate or nicotinic acid with an LDL-lowering drug. When triglycerides are >200 mg/dL, non-HDL-C is a secondary target of therapy, with a goal 30 mg/dL higher than the identified LDL-C goal.
- For moderately high-risk persons (2+ risk factors and 10-year risk 10% to 20%), the recommended LDL-C goal is <130 mg/dL; an LDL-C goal <100 mg/dL is a therapeutic option on the basis of available clinical trial evidence. When LDL-C level is 100 to 129 mg/dL, at baseline or on lifestyle therapy, initiation of an LDL-lowering drug to achieve an LDL-C level <100 mg/dL is a therapeutic option on the basis of available clinical trial evidence.
- Any person at high risk or moderately high risk who has lifestyle-related risk factors (e.g., obesity, physical inactivity, elevated triglyceride, low HDL-C, or metabolic syndrome) is a candidate for TLC to modify these risk factors regardless of LDL-C level.
- When LDL-lowering drug therapy is employed in high-risk or moderately high-risk persons, it is advised that intensity of therapy be sufficient to achieve at least a 30 percent to 40 percent reduction in LDL-C levels.
- For people in lower-risk categories, recent clinical trials do not modify the goals and cutpoints of therapy.

Updates and Reminders from BCBSNC’s EDI Services

North Carolina Providers Submit High Volumes of Electronic Claims

BCBSNC routinely encourages health care providers to file claims electronically. As a result, North Carolina providers have responded by submitting the majority of their claims electronically. As of the end of May 2006, providers have submitted over 11.5 million professional claims. Of that amount, 86 percent were electronically submitted, compared to 82 percent during this same period in 2005.

Through the end of May 2006, hospital providers submitted over 1.2 million institutional claims. Of that amount, 92 percent were electronically submitted, compared to 90 percent this same time last year.

The increase in electronic claim percentages over the past year is, in part, a result of transition to the HIPAA Compliant 837 claim formats. The 837 claim formats enable health care providers to submit corrected and secondary claims electronically. Many health care providers now enjoy this paperless method of claim submission compared to hours of stamping paper claims “corrected,” and copying primary payer EOBs.

BCBSNC appreciates providers utilizing the convenience of electronic claim submission. It enables us to process claims more quickly. See the chart below for details on how to submit corrected and secondary 837 claims, as well as other helpful electronic claim filing reminders.

<table>
<thead>
<tr>
<th>BCBSNC Electronic Claims Filing Reminders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Verify Eligibility Electronically - Before Service</strong></td>
</tr>
<tr>
<td>• Blue e</td>
</tr>
<tr>
<td>• HIPAA 270/271 Eligibility Inquiry</td>
</tr>
<tr>
<td><strong>Target 100% Electronic Claims Filing</strong></td>
</tr>
<tr>
<td>• 837 Secondary Claims</td>
</tr>
<tr>
<td>• 837 Corrected Claims</td>
</tr>
<tr>
<td><strong>837 Secondary Claim Requirements</strong></td>
</tr>
<tr>
<td>• 837 Institutional Claim</td>
</tr>
<tr>
<td>• Loop 2320 - Payer Prior Payment:</td>
</tr>
<tr>
<td>• AMT segment; AMT01 qualifier = C4;</td>
</tr>
<tr>
<td>• Prior Payer Allowed Amount:</td>
</tr>
<tr>
<td>• AMT segment; AMT01 qualifier = B6</td>
</tr>
<tr>
<td>• 837 Professional Claim</td>
</tr>
<tr>
<td>• Loop 2320 – COB Payer Paid Amount:</td>
</tr>
<tr>
<td>• AMT segment; AMT01 qualifier = D;</td>
</tr>
<tr>
<td>• Prior Payer Allowed Amount:</td>
</tr>
<tr>
<td>• AMT segment; AMT01 qualifier = B6</td>
</tr>
<tr>
<td><strong>837 Corrected Claim Requirements</strong></td>
</tr>
<tr>
<td>• 837 Institutional and Professional</td>
</tr>
<tr>
<td>• Loop 2300; Segment CLM05-3</td>
</tr>
<tr>
<td>• 5 – late charges</td>
</tr>
<tr>
<td>• 7 – replacement of claim</td>
</tr>
<tr>
<td>• 8 – Void/cancel prior claim</td>
</tr>
<tr>
<td><strong>Avoid Electronic Claims Filing Errors</strong></td>
</tr>
<tr>
<td>• Submit</td>
</tr>
<tr>
<td>• Valid Member ID Numbers</td>
</tr>
<tr>
<td>• Valid Code Sets</td>
</tr>
<tr>
<td>• Applicable Accident/Onset Dates</td>
</tr>
</tbody>
</table>
Updates and Reminders from BCBSNC’s EDI Services (Continued from page 18)

North Carolina Providers Submit High Volumes of Electronic Claims

### Additional BCBSNC EDI Reminders

<table>
<thead>
<tr>
<th>Keep EDI Services Informed</th>
<th>New Provider Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clearinghouse Relationships</td>
</tr>
<tr>
<td>Correct Mailed Back Claims</td>
<td>Resubmit Electronically</td>
</tr>
<tr>
<td>Check Claim Status Electronically</td>
<td>Blue e</td>
</tr>
<tr>
<td></td>
<td>HIPAA 276/277 Claim Status Inquiry</td>
</tr>
<tr>
<td>Automatically Post Payments</td>
<td>Retrieve HIPAA 835 Remittance</td>
</tr>
<tr>
<td></td>
<td>Implement Automated Posting Software</td>
</tr>
<tr>
<td>Adopt Electronic Funds Transfer</td>
<td>EFT Form - <a href="http://www.bcbsnc.com/providers/edi">www.bcbsnc.com/providers/edi</a></td>
</tr>
<tr>
<td></td>
<td>Phone - BCBSNC Financial Services (919) 765-7063</td>
</tr>
</tbody>
</table>

### Help Patients Become Tobacco Free

There are five As when it comes to getting folks to kick the tobacco habit – ask, advise, assess, assist and arrange. It’s not always an easy topic to bring up, but think of it as a caring gesture. Ask your patients if they use tobacco, then advise them to get the help they need to quit.

Quit Now NC, **1-800-QUIT-NOW (784-8669)**, is a great resource to suggest to all of your patients. This is a toll-free telephonic support service available to all North Carolinians. Specially trained coaches are able to handle calls in both English and Spanish, and they can be reached from 8 a.m. to midnight, seven days a week. They also specialize in coaching youths as well as adults.

Referring members is easy. Go to [quitlineNC.com](http://quitlineNC.com) and download the fax referral form. Or you can call their toll-free number with your patient’s information.

### Additional Benefits for BCBSNC Members

In addition to the five As, BCBSNC members have access to a Quit Kit, discounts on over-the-counter tobacco cessation products, an online tobacco cessation support module, discounts on counseling sessions offered at Kerr Health Centers and discounts on classes offered through the N.C. American Lung Association. Members can get more details about these additional program benefits by going to [bcbsnc.com](http://bcbsnc.com), clicking on “Member Health Partnerships,” then “Tobacco Free.”

To encourage tobacco cessation among our members, Blue Cross and Blue Shield of North Carolina recognizes the important role that providers play in advising and supporting patients in quitting. To that end, patients who use tobacco are eligible for coverage of office visits specifically scheduled to discuss tobacco cessation strategies and medications. Office visits for the treatment of tobacco use (ICD-9 code 305.1) with the appropriate level Evaluation and Management CPT codes are paid according to the fee schedule.
Updates and Reminders from BCBSNC’s EDI Services (Continued from page 19)

HB 636 Filing Instructions for Anatomic Pathology Services

This information is offered as a service to providers. If you have any questions about this North Carolina state law and its application to you, please consult your own counsel. Blue Cross and Blue Shield of North Carolina (BCBSNC) is not subject to this law and is not an enforcement mechanism.

House Bill 636, enacted by the North Carolina legislature, requires disclosures of markups by physicians, dentists, podiatrist and hospitals for anatomic pathology services. The bill defines “anatomic pathology services” to mean histopathology, cytopathology, hematology, subcellular and molecular pathology, and blood-banking services performed by pathologists.

Effective December 1, 2005, the new law made it a class 3 misdemeanor, or subject to licensing board action, for hospitals and persons licensed to practice medicine, podiatry or dentistry “to bill a patient, entity or person for anatomic pathology services in an amount in excess of the amount charged by the clinical laboratory for performing the service unless the licensed practitioner discloses conspicuously on the itemized bill or statement, or in writing by a separate itemized disclosure statement” (in 10 point font or higher) all three of the following:

1) The amounts charged by the laboratory for the anatomic pathology service.
2) Any other charge that has been included in the bill.
3) The name of the licensed practitioner performing or supervising the anatomic pathology service. There are two exceptions to this rule: 1) when the licensed practitioner performs or supervises the anatomic pathology service, or 2) when the physician who performs or supervises the service is employed and paid by a hospital or group practice to perform the service.

In addition, all bills for anatomic pathology services submitted to patients or entities for payment must contain the name and address of the lab performing the professional component of the service. This requirement is not limited to doctors, dentists, podiatrists or hospitals, but is required of all providers who submit bills for such services.

For providers that file electronically, the following instructions will enable you to include markups and other information for anatomic pathology services on your electronic claims:

837 Professional Claims

Additional information should be submitted in the 2300 loop under the Claim Note [NTE] segment. Please use the qualifier ADD in NTE01. All additional information should go in the subsequent NTE02. There are 80 characters available for use. See 837 Professional Implementation Guide, pages 245-247.

837 Institutional Claims

Additional information should be submitted in the 2300 loop under the Billing Note [NTE] segment. Please use the qualifier ADD in NTE01. All additional information should go in the subsequent NTE02. There are 80 characters available for use. See 837 Institutional Implementation Guide, pages 208-209.

NDC and Drug Pricing Information Can Be Included on the HIPAA 837 Claim Formats

BCBSNC can accept NDC and drug pricing information on HIPAA 837 claims. The location for NDC and related pricing is the same for both the 837 institutional and the 837 professional claim formats. Here’s more about where to put this information on the 837 claim form:

- **837 Drug Identification**
  Loop 2410; Segment LIN; N4 Qualifier; NDC code

- **837 Drug Pricing**
  Loop 2410; Segment CTP; Unit Price; Quantity;
  Composite Unit of Measure Qualifier
  - F2 International Unit
  - GR Gram
  - ML Milliliter
  - UN Unit
BCBSNC Network Management

BCBSNC Network Management is responsible for developing and supporting relationships with the provider community. Network Management staff are dedicated to serving as a liaison between you and BCBSNC and are available to assist you with a variety of issues, including:

- Questions regarding BCBSNC contracts, policies and procedures
- Changes to your organization including:
  - Opening/closing locations
  - Change in name or ownership
  - Change in tax ID number, address or phone number
  - Merging with another group
- Educational needs

BCBSNC Network Management field offices are located throughout the state and are assigned to support the provider community by specific geographical region.

Here is a listing of our Network Management offices and their respective contact information:

<table>
<thead>
<tr>
<th>Office</th>
<th>Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hickory Office</td>
<td>P.O. Box 1588</td>
<td>(877) 889-0002, (828) 431-3127</td>
</tr>
<tr>
<td></td>
<td>Hickory, NC 28601</td>
<td>Fax: (828) 431-3155</td>
</tr>
<tr>
<td>Charlotte Office</td>
<td>P.O. Box 35209</td>
<td>(704) 561-2740, (800) 754-8185</td>
</tr>
<tr>
<td></td>
<td>Charlotte, NC 28235</td>
<td>Fax: (704) 676-0501</td>
</tr>
<tr>
<td>Raleigh Office</td>
<td>2501 Aerial Center Drive, Suite 225</td>
<td>(919) 469-6935, (800) 777-1643</td>
</tr>
<tr>
<td></td>
<td>Morrisville, NC 27560</td>
<td>(Please note new number)</td>
</tr>
<tr>
<td></td>
<td>Fax:</td>
<td>(919) 469-6909</td>
</tr>
<tr>
<td>Greenville/Fayetteville/Wilmington Offices</td>
<td>2005 Eastwood Road, Suite 201</td>
<td>Phone: (877) 889-0001, (910) 509-0635</td>
</tr>
<tr>
<td></td>
<td>Wilmington, NC 28403</td>
<td>Fax: (910) 509-3822</td>
</tr>
<tr>
<td>Greensboro Office</td>
<td>The Kinston Building</td>
<td>Phone: (336) 316-5374, (888) 298-7567</td>
</tr>
<tr>
<td></td>
<td>2303 W. Meadowview Rd, Greensboro, NC 27407</td>
<td>(Please note new number)</td>
</tr>
<tr>
<td></td>
<td>Fax:</td>
<td>(336) 316-0259</td>
</tr>
</tbody>
</table>
Blue Cross and Blue Shield of North Carolina (BCBSNC) updates its online list of services and procedures each quarter that require prior Plan approval. Providers and members should refer to this list before any scheduled procedure and follow the outlined protocol. Prior Plan approval (also referred to as prospective review, prior authorization or certification) is the process by which certain medical services or medications are reviewed against health care management guidelines prior to the services being performed.

**Reviews are done to confirm the following:**

- Member eligibility
- Benefit coverage
- Compliance with BCBSNC corporate medical policy regarding medical necessity
- Appropriateness of setting
- Identification of comorbidities and other problems requiring specific discharge needs
- Identification of circumstances that may indicate a referral to concurrent review, discharge services, case management or Member Health Partnerships™.

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**Policy Change for CPT Code 99051**

Effective July 1, 2006, Blue Cross and Blue Shield of North Carolina (BCBSNC) made revisions to its policy for procedure code 99051 (Service[s] provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.) For providers with posted, regularly scheduled evening, weekend or holiday hours, reimbursement will be considered for procedure code 99051 in addition to the basic service for claims received for dates of service on or after July 1, 2006. This change applies to the BCBSNC benefit plans of Blue Care®, Blue Options™, and Classic Blue®.
Medicare Claims Adjustments

Effective February 8, 2006, the Deficit Reduction Act (DRA) of 2005 passed into law. This new legislation includes several revisions to payment procedures within the Medicare program. One notable change that providers should be aware of is an update to the 2006 rates for services paid under the Medicare Physician Fee Schedule (MPFS). Essentially, this revision reverses an earlier decision to reduce rates by 4.4 percent. Under this new legislation, the DRA reinstates the original 2005 rates for all services rendered on or after January 1, 2006.

As a result of this decision, the Centers for Medicare and Medicaid Services (CMS) is mass adjusting all claims received before February 8, 2006, and reprocessing with the updated rates. CMS has also instructed all Medicare and Medigap secondary contractors, including Blue Cross and Blue Shield of North Carolina, to adjust applicable claims for secondary liability.

As part of our compliance efforts with the DRA legislation, it’s estimated that BCBSNC will adjust nearly 250,000 claims. To help keep providers informed, BCBSNC would like to share some important details about the adjustment process:

- BCBSNC began the adjustment process in mid-June.
- Claims are being processed at an accelerated rate with many claims being paid within the same week.
- BCBSNC is not issuing “lump sum” payments like CMS. Our adjustments will be issued in the form of several aggregate payments over several weeks.

- The BCBSNC claims payment systems have undergone system enhancements to address this temporary operation. As a result, you may receive checks for very small amounts of money, or checks may appear on unfamiliar paper stock. **Please do not return checks to BCBSNC as this will delay and complicate the settlement process.**
- Some Notification of Payments (NOPs) may also appear in a different format than you are used to seeing.
- Members are held harmless by CMS, BCBSNC and their participating providers for any changes in copayments and deductibles that result from these adjustments.
- Not all providers will receive additional payments. Only those impacted by the Medicare adjustments will have their claims reprocessed.
- These adjustments apply to CMS-1500 claims submitted through providers’ Medicare- crossover partners.

CMS will not complete submissions to secondary carriers until the end of July 2006, which means providers may see DRA payments from BCBSNC for the next several months. **Please do not resubmit Medicare claims to BCBSNC for adjustment. CMS will submit claims on your behalf.**

If you have questions, please contact your local BCBSNC Network Management field office.
Release of Medical Records

At times, it is necessary for Blue Cross and Blue Shield of North Carolina (BCBSNC) to request medical records from you in order to determine appropriate claims payment, ensure contractual compliance or perform quality improvement activities.

Under HIPAA guidelines, no additional authorization is needed when medical records are requested for purposes of claims processing. Providers participating with Blue Cross and Blue Shield of North Carolina should be aware that medical records requested for the purpose of claims processing fall within BCBSNC “payment and health care operations” as those terms are defined in the HIPAA Privacy Rule.

Contracting providers have agreed to provide Blue Cross and Blue Shield of North Carolina with medical records as requested without further payment or authorization from the member or Blue Cross and Blue Shield of North Carolina. Also, medical records copying fees, administrative (S9981) and medical records copying per page (S9982) will be considered incidental to Evaluation and Management services, Surgical services and Laboratory services. Separate reimbursement is not allowed for S9981 and S9982.

Please do not send medical records unless requested by Blue Cross and Blue Shield of North Carolina. When sending requested medical records, providers are asked to please complete and return the Blue Cross and Blue Shield of North Carolina record request form. Blue Cross and Blue Shield of North Carolina record request forms are sent separately from the provider’s Notification of Payment or Explanation of Payment and will be only sent to the provider who needs to submit the records in question.