



Blue LINKSM

News from Blue Cross and Blue Shield of North Carolina

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- Ancillary
- Pharmacy

www.bcbsnc.com



BlueCross BlueShield of North Carolina

Blue Link Now Online!



For your convenience and easy reference, *Blue Link* is now available online at www.bcbsnc.com. Just click on the Provider Portal and you'll find current and past issues of *Blue Link* in the "Resources" section. *Blue Link* online is a great way to ensure that everyone in your office gets the latest news and updates from Blue Cross and Blue Shield of North Carolina!

BCBSNC Files Plan to Convert to For-Profit Company



Blue Cross and Blue Shield of North Carolina (BCBSNC) is embarking on a new course. In early January, we formally filed our plan to convert to a for-profit company. Under the plan and in accordance with a 1998 law passed by the General Assembly, BCBSNC would issue 100 percent of its stock at the time of conversion to an independent, charitable foundation dedicated to promoting the health of North Carolinians.

"With the plan, we are following the clear roadmap established by the General Assembly in 1998," said BCBSNC president and CEO, Bob Greczyn. "This plan upholds three essential principles: that the independent foundation receive 100 percent of our stock, that Blue Cross and Blue Shield of North Carolina remain a North-Carolina based company, and that, upon conversion, the company be

allowed to operate as all other for-profit health care companies do."

Why Convert?

In addition to benefiting North Carolina with the creation of one of the largest health care foundations the state has ever had, converting to a for-profit company will help BCBSNC remain a strong, stable and reliable insurer for our customers. We believe conversion will give us greater flexibility and access to capital to finance customer service improvements and invest in products and services to meet ever-changing customer needs.

"After converting, we think the company will have a greater ability to invest in new capabilities like e-commerce, health programs and disease management for customers coping with chronic illnesses like asthma, diabetes or heart trouble. We will also be better able to

(Please see Plan to Convert on page 2)

Plan to Convert (continued)

streamline administration and claims processing—reducing paperwork, increasing efficiency and improving service to our customers," Greczyn said.

Conversion to a for-profit company will not itself increase premiums, change health care benefits or affect our customers' choice of providers. Rising medical costs will continue to be the primary factor driving increases in health insurance premiums.

For More Information

We at BCBSNC remain committed to good corporate citizenship and community service. We will continue to give back to our customers and to the state that has supported our company for over 68 years. If you would like to learn more about our plans to convert, just visit us online at www.bcbsnc.com or contact your local BCBSNC Network Management field office.

PARTNERS Products to Be Fully Integrated With BCBSNC Plans

Over the next two years, Blue Cross and Blue Shield of North Carolina (BCBSNC) and PARTNERS National Health Plans of North Carolina, Inc. will fully integrate our North Carolina commercial group insurance products under the BCBSNC brand. BCBSNC acquired PARTNERS in October 2001.

Benefits of Product Integration

This change will ultimately give our provider network access to the combined 2.5 million customers served by BCBSNC and PARTNERS. It will also allow us to streamline processes so we can serve you more efficiently. We will eliminate duplication by transitioning all providers to BCBSNC contracts and fee schedules over the next two years.

This product integration is designed to maximize our collective strengths and capabilities and provide better service to our customers across the state. As part of the Blue Cross and Blue Shield Association, BCBSNC has the most recognized health insurance brand in America, as well as comprehensive products and value-added programs, such as Alt Med BlueSM and Vita BlueSM. PARTNERS has an impressive record of efficiency of operations and a strong presence in the Triad area.

(continued)

Partners Products (continued)

When Will It Start?

We will begin migrating PARTNERS' North Carolina group customers to BCBSNC products upon their policy renewal dates in 2003. We expect this change to be seamless to our customers. We will give you adequate and reasonable notice of any changes that will affect you. If you have questions, please contact your local BCBSNC Network Management field office.

New for 2002: Your Healthy Best[®] — Specialty Services

Your Healthy Best—Specialty Services is a free, confidential program offered to eligible BCBSNC members who have any of the 14 chronic, progressive diseases listed below:

- rheumatoid arthritis
- multiple sclerosis
- Parkinson's disease
- systemic lupus erythematosus (SLE)
- myasthenia gravis
- sickle-cell anemia
- cystic fibrosis
- hemophilia
- scleroderma
- polymyositis
- chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- amyotrophic lateral sclerosis (ALS)
- dermatomyositis
- Gaucher's disease

Program participants will receive educational materials and personalized support from specially trained registered nurses, as well as Web access to disease-specific information and services.

If you would like more information or if you need to refer a BCBSNC patient to this program, please call us at **1-800-218-5295**. Please share this number with any of your BCBSNC patients who may benefit from this free and confidential specialty service.

CHECKPOINT and CHECKMATE: Effective Diabetes Tools

Last fall, we mailed two helpful tools in the care of your BCBSNC diabetic patients to over 2,000 primary care physicians and endocrinologists across the state. Diabetes CHECKPOINT is an easy-to-use flow sheet, which can be used with your patient charts to track the care of diabetic patients. Diabetes CHECKMATE is a complementary, patient-oriented diabetes management guide.

Available to you through BCBSNC's *Your Diabetes Care* program, both documents were developed by the Medical Review of North Carolina in collaboration with health care providers, insurance companies,

government agencies and nonprofit organizations dedicated to diabetes care across the state.

A brief survey was also included in the mailing and responses indicate that 97 percent of offices feel the information contained in the documents is accurate and credible. 82 percent stated they plan to incorporate these tools into their practice patterns.

If you would like to order either CHECKPOINT or CHECKMATE documents or need more information about the *Your Diabetes Care* program, please call us at **1-800-218-5295**.

State Health Plan: Retroactive Copayment Changes

As you'll recall, benefit changes for the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan were announced last summer and were effective July 1, 2001. We want to make you aware of some retroactive changes that were recently made by the 2001 session of the North Carolina General Assembly.

Retroactive to July 1, 2001

One of the major changes applies to the \$15 professional services copayment, which is taken for all professional services except laboratory, pathology, and radiology services. Per the General Assembly's recent decision, the \$15 copayment no longer applies to injections (including allergy shots), IV therapy or cardiac rehabilitation services. The copayment does apply if you bill for an office visit in addition to these services.

Adjustments Will Be Made

This change is retroactive to July 1, 2001. Therefore, the Claims Processing Contractor will be making adjustments to previously processed claims for which copayments were taken prior to this ruling. You do not need to call us to request the adjustment. You will receive a revised Notification of Payment.

Due to the large volume of claims to be adjusted, it may take a while before all adjustments are completed. However, we will make every attempt to complete them as soon as possible. If your patients have already paid copayments for these services, please reimburse them once you receive your revised Notification of Payment.

If you have any questions, please contact State Customer Services at **1-800-422-4658**.



**BlueCross BlueShield
of North Carolina**

State Health Plan: Medical Policies Available Online



The North Carolina General Assembly recently passed legislation which requires that medical policies for the State Health Plan must be made available for comment to employing units, health benefit representatives, providers, and other interested persons at least 30 days prior to policy adoption.

You can view State Health Plan medical policies on the Web at:

<http://www.nc-shp.com/>

If you have comments on any of the policies, please submit them to the attention of Kyle Howard, manager of State Medical Review, via fax at **919-765-4891** or in writing at:

State Medical Review
PO Box 30111
Durham, NC 27702-3111

State Health Plan: Preadmission Certification vs. Prior Approval



Did you know that "preadmission certification" and "prior approval" have distinct meanings under the State Health Plan? When calling State Customer Services to verify benefits, it is important that you give specific information about the services being rendered so the representative can effectively determine which of the two are needed.

If the patient requires an inpatient stay, then an inpatient authorization is required. Under the State Health Plan, this is called "preadmission certification," which may be obtained by calling **1-800-672-7897**.

"Prior approval" is required for certain procedures, so it's very important to know the specific procedure that will be performed when you call us. To obtain prior approval or to see if a procedure requires prior approval, please call us at **1-800-422-1582**.

Filing Immunizations to the State Health Plan and NC Health Choice for Children



The purpose of this filing procedure is to permit monitoring of the immunization status of State Health Plan and NC Health Choice for Children members for HEDIS reporting purposes. When billing immunizations, we ask that you file as follows:

- Each immunization must be filed on a single line on the HCFA-1500 claim form with its specific CPT-4 code.
- For state-supplied vaccines, the modifier (-52) for reduced service must be appended to the specific CPT code. This modifier signifies that you are only requesting payment for administering a state-supplied vaccine.
- For vaccines that are not supplied by the state, the CPT code without the reduced service modifier must be used to signify that you are requesting payment for the cost of the vaccine as well as the administration fee.
- Please note that codes **90471**, **90472**, and **90749** are not eligible for reimbursement and will be denied.

Example 1: Patient has a state-supplied MMR (measles, mumps and rubella) vaccine. File using code **90707-52** in block 24D of the HCFA-1500.

Example 2: Patient has a tetanus shot which was supplied by the doctor's office and not by the state. File with code **90703** in block 24D.

The administration fee for state-supplied vaccines depends on the number of actual administered immunizations:

- The fee is \$13.71 for a single vaccine.
- The fee is \$27.42 divided by the number of injections for multiple vaccines. The total administration fee for all immunizations given at a visit cannot exceed this amount.

If you have further questions, please contact State Customer Services at **1-800-422-4658**.

Blue Card®: How to Avoid Claim Delays and Rejections

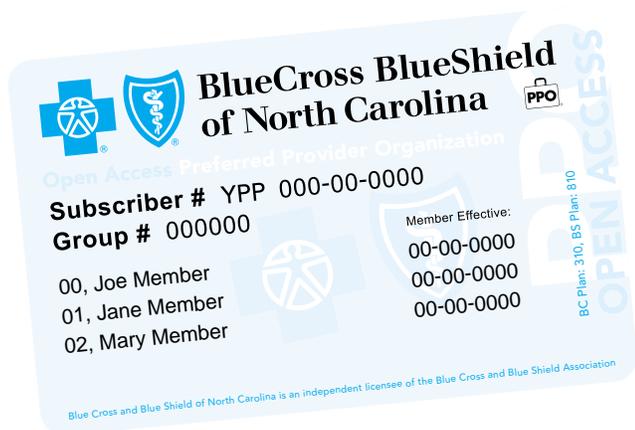
We'll let you in on a secret...one of the biggest reasons for a claim delay for a BlueCard member is incorrect or missing alpha prefixes and identification numbers. To avoid future delays, follow these simple steps when filling out a claim form for a BlueCard member:

- **Make copies of the front and back of the member's ID card** and pass this key information on to your billing staff. Be sure that the member provides you with the most current ID card. When you're referring a patient or a patient's information to another provider and there is not a face-to-face encounter, please include a copy of the patient's ID card.
- **Look for the three-character alpha prefix.** The alpha prefix identifies BlueCard membership and the member's Blue Cross and Blue Shield Plan or national account. It is critical for confirming membership and coverage. Alpha prefixes sometimes change, so be sure to recheck the patient's ID card periodically.
- **Call BlueCard Eligibility at 1-800-676-BLUE (2583)** to verify the member's eligibility and coverage. Business hours are 7 a.m. to 8 p.m., Monday through Friday. An operator will ask you for the alpha prefix and will connect you directly to

the member's Blue Cross and Blue Shield Plan. If you call after that Plan's regular hours, you will get a message stating their business hours. Please note that the hours of Blue Plans' customer service units vary.

- **If you can't find the alpha prefix on the ID card**, this may indicate that the member's claim is handled outside the BlueCard program. Check the member's ID card for instructions on how to file these claims or for a telephone number to call for further assistance. If information is not available, call the BCBSNC BlueCard Customer Service department at **1-800-487-5522**.
- **Complete the claim form** and include the member's complete identification number—including the three-character alpha prefix—once the member receives care. Do not make up an alpha prefix. Be sure you price the claim according to your contract with Blue Cross and Blue Shield of North Carolina (BCBSNC).
- Submit completed BlueCard member claims to:

BCBSNC
P.O. Box 35
Durham, NC 27702



BCBSNC Prescription Drug Benefit Refresher



Membership in our new suite of health care products—Blue Care®, Blue Choice®, Blue OptionsSM and Classic Blue®—has grown substantially. As health care providers, chances are you've already had numerous encounters with members enrolled in these products.

With this in mind, we would like to remind you of a few key differences in the 3-Tier prescription drug benefits between some of BCBSNC's older products, like Personal Care Plan^{SM1}, MedPoint^{SM1} and Preferred Care® *Select*, and the new Blue products. Please note that benefit plans will differ. You may verify benefits by calling the Customer Service number listed on the member's ID card.

Extended Supply

The new benefits allow members to obtain an extended supply (up to 90 days) of their prescription from any participating pharmacy — no longer from just those pharmacies participating in the extended-supply

network. It is required that a member must first fill a 30-day supply before getting an extended supply.

Single Copayment for Each 30-Day Supply

Members will be expected to pay a single copayment for each month's supply. In the past, most members were able to receive a three-month supply for only two copayments at participating extended-supply pharmacies.

30-Day Supply vs. 34-Day Supply

Our older products allowed up to a 34-day supply for only one copayment. However, the benefits under the new Blue products require a single copayment for up to a 30-day supply. Therefore, a prescription that is processed for a 34-day supply under the new Blue plans will charge the member two copayments because the system will consider this a two-month supply. If this happens, you may need to adjust the days supply to 30 days or less.

Rx Prior Approval Fax Request Forms Online



BCBSNC has recently added five new drugs to the Prior Approval list. Cox II inhibitors (Celebrex and Vioxx as of 1/1/02; Bextra as of 2/1/02) and antifungals (Lamisil and Sporanox as of 1/1/02) now require prior approval for our HMO products, which are Personal Care Plan and Blue Care.

The appropriate fax request forms for prior approval for these drugs are available online at www.bcbsnc.com. Click on "Prescription Drug Search" under the Provider portal. Then, click on the link to "Prior Approval and Quantity Limitations." There you'll find links to PDF versions of both fax request forms along with a search tool to identify your region's dedicated fax number. You may wish to review this Web site periodically for updates to our prescription drug Prior Approval and Quantity Limitations programs.

www.bcbsnc.com



Recent Tier Changes for Drugs



Drugs moved to Tier 2 on 12/1/2001	Drugs moved to Tier 2 on 1/1/2002	Drugs moved to Tier 3 on 1/1/2002	Drugs moved to Tier 2 on 1/22/02
Gleevec Valcyte Yasmin Canasa Neurontin solution Trileptal solution DuoNeb Nexium	Rebetol Alphagan P Zyrtec-D Astelin	Duragesic	Axert

You can always find an up-to-date formulary online at our Web site www.bcbsnc.com. To find out the tier status of other drugs, use the online "Prescription Drug Search" feature.

New For 2002: Injectable Drug Vendor Network



In early 2002, BCBSNC will introduce a network of specialty vendors who will supply select injectable drugs directly to your office. You will be able to order injectable drugs from any of the vendors participating in the network.

The vendor will ship the drugs directly to your office and will bill BCBSNC directly on your behalf—reducing time and paperwork for your office, as well as taking away the financial risk you may have encountered when supplying injectable drugs to patients in the past. If you choose, you can continue to purchase injectable drugs yourself and bill BCBSNC through your office. Utilization of the injectable drug vendor network will be voluntary.

In the near future, we will provide you with more detailed information about this new network, including a listing of participating vendors and injectable drugs included in the program. In the mean time, please visit www.bcbsnc.com for any updates on this specialty vendor network.

Injectable Drug Benefits

Please note that for most BCBSNC members, self-administered injectable drugs are covered as a prescription drug benefit. Injectable drugs requiring supervision by a health care professional should be filed as a medical expense.

For a list of commonly prescribed self-administered injectable drugs that are covered under BCBSNC prescription drug benefits, visit www.bcbsnc.com or call BCBSNC Customer Service with questions.

Pre-Book Flu Shots for 2002-2003 Season



Although we're just now coming out of peak flu season, now is the time to pre-order your supply for the 2002-2003 season. Pre-ordering will ensure that you are able to receive the flu vaccine supplies you need for your practice before the season starts this fall and winter. Here are the names and numbers of the manufacturers that The Centers for Disease Control and Prevention recommend you work with to get your supply:

- **Aventis Pasteur** – 1-800-822-2463
- **Wyeth-Ayerst Laboratories** – 1-800-358-7443
- **Henry Schein** – 1-800-772-4346

Important Claim Filing Reminders



Red and White = Do It Right

When submitting HCFA-1500 and UB92 claims, it's imperative that you send us the original red and white forms. Copied, black and white forms cannot be read by our claims processing equipment and have to be manually keyed, which results in unnecessary delays.

Do Not Submit Claims for Future Services

We continue to receive a high volume of claims that are filed in advance for future dates of service. We'd like to remind you that we cannot accept claims for dates of service that have not yet occurred.

For instance, if a patient receives services from January 2nd through January 15th, and you prefer to file them together, please wait until after January 15th to send in your claim. This will prevent your claim from being processed incorrectly or mailed back to you.

Multiple Services on Same Day

When you have two lines of the same service to report for one date, please combine them to one line with the charges and unit field increased appropriately. Filing as two separate lines will result in a denial of the second service as a duplicate charge.

Post-Op Office Visits

Remember, you do not need to collect a copayment for post-operative office visits during surgical global periods. If you have questions about when to collect copayments, please refer to your *BCBSNC Physician Guide* or contact your local Network Management field office.



Blue eSM Update for Hospitals



Due to internal processing issues, we have temporarily suspended the function for submitting observation cases electronically through Blue e. Until further notice, please call Medical Resource Management at **1-800-672-7897** to report observation and admission cases.

We regret any inconvenience this may cause your facility. Please be assured that we are working diligently to resolve the problem. We'll let you know in future issues of *Blue Link* when the capability to report observation cases via Blue e is restored.

Blue eSM Audit and Error Reports



In ongoing efforts to improve communication, reduce paper and the time it takes to resolve a claim, we have discontinued the mailing of paper audit and error reports to those of you who have the ability to receive the information electronically through Blue e.

Currently, many of you and your clearinghouses use Connect Mailbox, an electronic mailbox system, to transmit your claims to BCBSNC. You can also use Connect Mailbox to retrieve your audit and error reports the next business day. We think you'll agree that this process is much faster than the seven to ten business days it takes to receive the reports by standard mail.

EDI Services of BCBSNC notified electronic providers, vendors and clearinghouses of this new process in late 2001. If you are a provider who transmits your claims directly to BCBSNC and you have not heard from your vendors regarding this change, please contact them immediately to make the necessary arrangements. If you are a provider who uses the services of a clearinghouse and you have not started receiving these reports directly from them, please contact your clearinghouse for more information.

Transition of FEP and State Medical Management Functions



As of January 14, 2002, pre-admission certification and length of stay assignment responsibilities for the Federal Employee Program (FEP) were transitioned from BCBSNC Medical Management to the FEP area.

In addition, pre-admission certification, length of stay assignment and rehabilitation review functions for the State Health Plan were transitioned from BCBSNC Medical Management to State Medical Review. FEP and State processes and benefit requirements were not affected.

- Please call **1-800-672-7897** for all BCBSNC, FEP and State Health Plan medical management needs. You will be prompted to choose FEP, State or BCBSNC business.
- The new fax number for State Medical Review is **919-765-4891**

Moving these functions to their respective areas will improve efficiency and the quality of service we provide to you and our members. For more information or if you have benefit questions, please contact FEP Customer Service at **1-800-222-4789** or State Customer Service at **1-800-422-4658**.

FEP: 2002 Benefits for Home Nursing Care



The Federal Employee Program (FEP) provides home nursing care for up to two hours per day by a registered or licensed practical nurse when the patient's attending physician orders the care.

Home nursing care is limited to 25 visits per calendar year under FEP Basic and Standard Options. If a member is enrolled in Basic Option, preferred providers must be used in order for the services to be covered. Home nursing care may be rendered and billed by a home health care agency, a visiting nurse association, a medical supply company or an independent registered nurse or a licensed practical nurse.

Home Nursing Care benefits are as follows:

FEP Basic Option – preferred providers only; patient responsible for \$20 copayment per visit

FEP Standard Option – when a preferred provider is rendering the care, the patient pays 10 percent coinsurance of the allowable amount after satisfying the calendar year deductible; if a nonpreferred provider renders the care, the patient is responsible for 25 percent of the allowable amount after the calendar year deductible is met.

Home nursing care services are not covered when:

- Requested by, or for the convenience of the patient, or the patient's family;
- Services consists primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication, or acting as a companion or sitter; or
- The nurse is an immediate relative or member of the household.

If additional information is needed, please call FEP Customer Service at **1-800-222-4739** or visit our Web site at www.fepblue.org.

www.bcbsnc.com



2002 Physician Workshops to Be Held in May (P)

Just a heads up that Blue Cross and Blue Shield of North Carolina will be hosting our annual physician workshops this May. Workshops will be held in the Eastern region, Triad/Triangle region, and Western region of our state, with specific cities and dates to be included with your invitations.

Be sure to plan to attend a workshop in your area this year, as we will be distributing the revised 2002 *Physician Office Guide* at the meetings. Watch your mailboxes for your invitation!

Hospitals, We Need Your Input! (F)

Many of our contracting hospitals with their own physician groups have expressed an interest in having regional workshops for the hospitals, as we already provide annual workshops throughout the state geared to the physician community.

But, first, the educational staff of BCBSNC's Network Management team would like to hear from you, our contracting hospitals, to see if the interest is widespread enough to warrant such an effort.

If you would like to see us include regional hospital workshops in our annual tour of the state, please fax your request to the attention of either Donna Mitchell, educational consultant, Western Region (west from Alamance County), or Andrea Brown, educational consultant, Eastern Region (east from Orange County), at **919-765-7109**. Please include the following information:

- Name
- Hospital Name and BCBSNC Provider Number
- Telephone Number
- E-Mail Address
- Topics of Interest
- How Far You Are Willing to Travel to Attend

Costly Wheelchairs Require Prior Plan Approval (P) (A)

Prior Plan Approval is required for any wheelchair that cost \$1500 or more for BCBSNC Personal Care Plan, Blue Care, MedPoint or Blue Choice members. Prior Plan Approval is required even if the equipment is rented. The reason for including rented wheelchairs is because we will only pay rental amounts up to the purchase price, which is based on the total cost of the wheelchair, including all parts and accessories.

Example #1:

Wheelchair – cost \$600.00
Special Back – cost \$200.00
Total - \$800.00

This chair would not require Prior Plan Approval as the total cost is under \$1500.

Example #2:

Wheelchair – cost \$1300.00
Special Back – cost \$400.00
Total - \$1700.00

This chair would require Prior Plan Approval as the total cost exceeds \$1500.

If a wheelchair with a total purchase price of \$1500 or over is currently being rented or is to be purchased, and the patient is a Personal Care Plan, Blue Care, MedPoint or Blue Choice member, please call us at **1-800-672-7897** to discuss Prior Plan Approval needs for the case in question.



Policy for Practitioners Pending Credentialing



Blue Cross and Blue Shield of North Carolina's (BCBSNC) current credentialing policy states that in order to receive the contracted reimbursement for covered services provided to a BCBSNC HMO, POS or PPO member, a practitioner must be credentialed by BCBSNC.

As of April 1, 2002, this policy will be enforced via the claims processing system. Claims for covered services provided to BCBSNC HMO, POS or PPO members by a nonparticipating practitioner in a participating provider group will be denied. The BCBSNC member will be held harmless, including any copayments, coinsurance, or deductibles.

Consistent With State Law

BCBSNC has made a commitment to our customers that only practitioners participating in our networks who have met the required credentialing standards will be eligible to treat them. Consistent with the requirements of state law, we have enhanced our credentialing process to be more efficient and to better serve our N.C. participating providers, without compromising this commitment to our customers. As a result of these enhancements, BCBSNC will issue a credentialing decision within 60 days or less from the date we receive a complete Uniform Credentialing Application from a practitioner.

Credentialing Process

Participating practitioners are encouraged to consider the time required to complete the credentialing process as you add new practitioners to your practices. To assist you in maintaining accessibility in circumstances where your practice, and or the new practitioner, is unable to submit the credentialing application in a timely manner, we have created a standard operating procedure that will allow reimbursement for covered services provided by a nonparticipating practitioner who is in the process of joining a BCBSNC participating practice. The following must apply:

- A credentialing application must have been submitted to BCBSNC and a determination on such application is pending, and

- The new practitioner must provide covered services to BCBSNC members under the direct supervision of a BCBSNC-similarly licensed and credentialed practitioner at the practice who signs the medical record related to such treatment and files the claim under his or her current provider number, and
- A written policy outlining the requirements of the supervision of such practitioners is maintained in the office, and
- A "Statement of Supervision Form" is completed and submitted to your local BCBSNC Network Management office (the form may be obtained by contacting your local Network Management office, if needed).

For a copy of the new standard operating procedure outlining the details of this process, or if you have questions, please call your local Network Management field office for further assistance.

Vision Care Service Administration to Change in May



Effective May 1, 2002, BCBSNC will resume responsibility for the administration of vision care services for our HMO and POS members. We will now be handling all related customer service, claims processing, utilization management and appeals functions as well as provider contracting aspects of our new vision care network.

One major change will be that routine eye exams will be covered at any participating provider that performs the service, which will be different from the way OptiCare Eye Health Network, Inc., currently handles eye exams. Also, all participating providers that own an optical dispensary will be required to provide BCBSNC HMO and POS patients with a prescription eyewear discount, which will now include disposable contacts.

If you have further questions, please contact your local BCBSNC Network Management field office.

Should Patients Still Choose a Primary Care Physician? P

In a word—yes. While some of our products do not require members to choose a primary care physician, we still strongly urge them to select and use one. Through member education, we remind our members that a primary care physician is one of their most important health care partners.

A primary care physician informs members of their health care options; documents their care and maintains their records; and saves members time and unnecessary copayments by recommending appropriate specialists, coordinating care with them, and informing them of such things as medical history and potential drug interactions.

BCBSNC members can change their primary care physician at any time. However, once a change has been made, members should contact their previous doctor to have records transferred in order to ensure continuity of care. If you are the treating physician, but not the primary care physician, we encourage you to find out the name of the primary care provider from the patient so that results can be sent to them for inclusion in the member's permanent medical record.

Doctors in the following specialties are available to be primary care providers:

- **Family Practice**
- **Internal Medicine**
- **General Practice**
- **Pediatrics**

Members may use our Web site— www.bcbsnc.com — to find and select a primary care provider in one of these specialties. Members may also look through a BCBSNC provider directory and call BCBSNC Customer Service to let us know whom they have chosen for their primary care. By choosing and using a primary care physician, members will be better able to maximize their health care benefits and receive appropriate care at the right time in the right setting.

Important Revenue Code Updates F

Effective May 1, 2002, BCBSNC will no longer accept the following revenue codes when submitted on a UB-92 form by a contracting provider:

- **510—clinic billing**
- **519—other clinic billing**
- **520—free-standing clinic billing**

Please note that any claim processed after April 30, 2002, will process according to this guideline—regardless of date of service.

This claims processing decision was made in order to better align our policy with industry standards, and because our members were incurring a financial liability with deductibles and coinsurance outside of the expected office visit copayment, when seeking care at professional offices located on a hospital campus or owned by a hospital entity.

For State Health Plan and NC Health Choice patients: Please consult your hospital's individual contract regarding reimbursement for these clinic services. If you need further clarification, please contact Gordon Daughtry or Zorba Howell at [919-881-2300](tel:919-881-2300).

If you have BCBSNC-related questions about this filing change, please contact a Network Management educational consultant at [919-765-3019](tel:919-765-3019) or [919-765-2160](tel:919-765-2160).

Blue Cross and Blue Shield of North Carolina would like to remind you of our claims adjudication policy. The policy, which can be found in Section 8 of the *Physician Office Guide*, allows for claims editing in certain situations. Beginning in mid-2002, our claims adjudication process will apply edits more systematically in the following situations:

- **Duplicate Submissions:** Edit will be applied if more than one claim is submitted for the same service or if the same service is included in one or more claims.
- **Diagnosis-to-Procedure Mismatch:** Edit will be applied to procedures that are matched with an unexpected diagnosis code.
- **Upcoded Services:** Edit will be applied to upcoded services including, but not limited to, inappropriate reporting of new patient evaluation and management services, consistent with CPT guidelines.

The Summer 2002 *Blue Link* will provide further information about our claims adjudication process.

Immunization Rates Continue to Increase

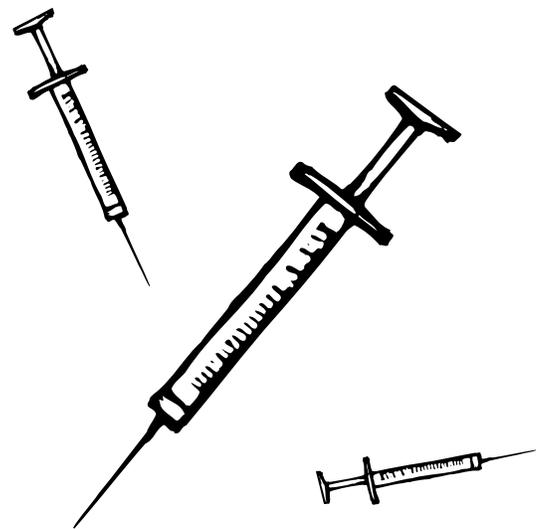


Thanks to the ongoing support and commitment of our provider community, BCBSNC continues to demonstrate significant increases in immunization rates for both children and adolescents. The Combination 2¹ rate for childhood immunizations increased from 54.0 percent in 1998 to 64.2 percent in 2000. The Combination 2² rate for adolescent immunizations increased from 0.2 percent in 1998 to 13.6 percent in 2000. Despite these increases, BCBSNC's rates remain below the 90th percentile benchmarks established by NCQA—68.1 percent for childhood and 36.6 percent for adolescent immunizations.

BCBSNC conducted a barrier analysis on the 2000 data to determine potential opportunities for improvement. Among the issues identified were the correlation between birth month and likelihood to receive childhood immunizations and the ongoing issue of incomplete medical record data. BCBSNC discovered that children born in the fall or winter were significantly less likely to be completely immunized by age two as compared to children born in the spring or summer. For example, 71.4 percent of children born during the summer of 1998 were fully immunized compared with only 59.1 percent of those born during the winter. The second area involves incomplete medical record documentation, particularly with regard to chickenpox. Please ask parents whether the child has received any shots since his or her last office visit and whether the child has had chickenpox. If yes, be sure to note the

date or the child's age at which he or she had chickenpox.

We appreciate your continued support as we strive to achieve the 90th percentile benchmarks for both childhood and adolescent immunization rates. If you would like information about our immunization interventions, please e-mail us at quality@bcbsnc.com.



¹ Two year olds that received four DTP or DTaP, three OPV or IPV, one MMR, two HiB, three hepatitis B, and at least one VZV.

² 13 year olds that received one MMR on or between the 4th and 13th birthdays or two MMRs between the 1st and 4th birthdays, three hepatitis B, and at least one VZV.

BCBSNC Standards for Medical Records, Facilities and Access to Care



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

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

- **Medical Records** – 85 percent of primary care physicians will attain a score of at least 85 percent on the medical records review.
- **Facility** – 95 percent of all primary care and OB/GYN physicians will attain a score of 100 percent on the facility site review.
- **Access to Care** – 95 percent of all physicians will attain a score of 100 percent compliance with the access to care standards.

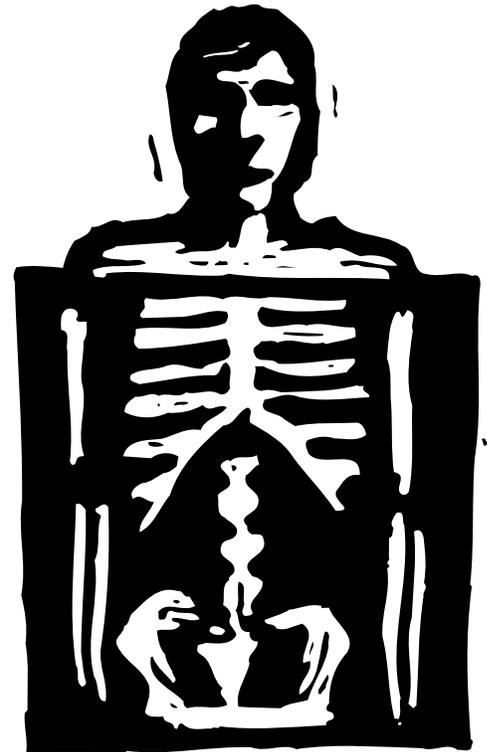
Since measurements began in 1995, we have seen a significant improvement in the results of our reviews. Our network physicians have demonstrated a strong desire to quickly correct any deficiencies.

Medical Records

The 2001 reviews, conducted in 485 practices, resulted in 97.5 percent of the practices meeting or exceeding BCBSNC's goal. Sixty-eight practices (14 percent) were found to be in 100 percent compliance with all standards being monitored. The requirement to have a discussion of smoking/ETOH and substance abuse continues to be the least met standard at 34.9 percent. In order to meet this standard, practices must have documentation of discussion around all three lifestyle issues. Most practices discuss smoking and ETOH, but fail to document substance abuse. Compliance with having a completed problem list in the record has always been lower than the expected goal, but is beginning to show improvement. In 2001, 76.9 percent of practices reviewed were in compliance with the problem list standard.

A medical record assessment is conducted in primary care practices with insufficient enrollment to support a complete medical record review. 94 percent of the practices where medical record assessments were conducted scored 100 percent on the monitored standards. As with medical record review results, the smoking/ETOH/ and substance abuse and problem lists standards were the least met.

Medical record assessments conducted on high volume practices, i.e., OB/GYN, resulted in 94.5 percent of the practices being in compliance with the monitored standards. The lack of problem lists and prominently posted allergies were the main concerns among this group.



BCBSNC Standards (continued)

Facility Site Reviews

Overall, 95.7 percent of the primary practices and 93.3 percent of the OB/GYN practices reviewed met the facility standards. Twenty primary practices and six OB/GYN practices did not have a dedicated emergency kit. The standard requires sufficient equipment/supplies to support life until a patient can be moved to an acute care setting. This means having on hand at least an ambu bag, airway and blood pressure cuff. These items should be together in a specific place, known to everyone on the staff, and ready for "grab and go" in case of emergency. Practices located on hospital campuses are not exempt from this patient safety standard. Availability of toilet facilities equipped for the physically challenged has improved.

Access to Care

The overall compliance rate with the access to care standards among primary care practices was 97.8 percent and among OB/GYNs, 99.2 percent. The overall compliance rate with the access to care standards among OB/GYNs was 99.2 percent. Translator services were found in 67 percent of primary practices and 60 percent of OB/GYN practices.

The only appointment wait-time standard found to have deficiencies was for routine physicals. Time spent in the waiting room for a scheduled appointment was met by 99 percent of the primary practices reviewed. We encourage you to not only move patients through the waiting room in a timely manner, but also limit— to the extent possible— the wait time in exam rooms, as this continues to be a source of dissatisfaction with patients.

BCBSNC's Access to Care Standards, Facility Standards, as well as our Member Rights and Responsibilities are included for your review in this issue. Look for the Medical Records Standards in the fall issue of *Blue Link*.

New CDC Antibiotics Guidelines

As physicians, you are faced every day with patients who want or demand antibiotics. You're caught in the middle—on one side, you've got a patient who is asking for an antibiotic so he or she can return to work as soon as possible, and on the other side, you've got your knowledge based on your diagnosis of the patient that antibiotics won't be effective.

Inappropriate Use of Antibiotics

In order to help you and your patients know when an antibiotic is the right course of treatment, the Centers for Disease Control and Prevention (CDC) has created new prescribing guidelines. Under the new guidelines, antibiotics should NOT be used for the following conditions:

- the common cold
- uncomplicated bronchitis, regardless of the duration of the cough
- a sore throat, unless a throat culture confirms a streptococcal infection
- simple sinus infection

Through patient education, we can all work together to try to change patient expectations and help them realize that inappropriate use of antibiotics threatens the success of antibiotic treatment for common infections. The past few decades have witnessed an unprecedented rise in the spread of antibiotic resistance determinants among disease-causing bacteria.

Save Antibiotic Strength Campaign

Blue Cross and Blue Shield of North Carolina is a member of the Coalition for Affordable Quality Healthcare (CAQH), a coalition of 26 of America's largest health plans and insurers serving more than 100 million people. CAQH has launched the Save Antibiotic Strength campaign to raise awareness about the critical issue of antibiotic resistance. Joining CAQH in this effort is the U.S. Centers for Disease Control and Prevention and the Alliance for the Prudent Use of Antibiotics.

Access to Care Standards for Visits to Primary Care Physicians



Blue Cross and Blue Shield of North Carolina HMO-POS-PPO

Waiting time for appointment:

Urgent health need that requires care within 24 hours

Pediatrics	see within 24 hours
Adults	see within 24 hours

Symptomatic nonurgent (example: cold with no fever)

Pediatrics	within 3 calendar days
Adults	within 3 calendar days

Follow-up of urgent care

Pediatrics	within 7 days
Adults	within 7 days

Chronic care follow-up (examples: blood pressure checks, diabetes checkup)

Pediatrics	within 14 days
Adults	within 14 days

Complete physical exam/health maintenance

Pediatrics	within 30 calendar days
Adults	within 60 calendar days

Time spent in waiting rooms:

For a scheduled appointment	After 30 minutes, the patient must be given an update on waiting time with an option of waiting or rescheduling the appointment. The maximum acceptable waiting time is 60 minutes.
Walk-ins	Walk-ins are discouraged, but reasonable efforts should be made to accommodate patients. Life-threatening emergencies must be managed immediately.
Work-ins (Patient called that day prior to coming)	After 45 minutes, the patient must be given an update on waiting time with an option of waiting or rescheduling. The maximum waiting time is 90 minutes.

Response time for returning calls after hours:

For an Urgent* Need	20 minutes
For a Nonurgent Need	1 hour

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

Office Hours – indicates hours during which appropriate personnel is available to care for members, i.e., MD, DO, FNP, PA.

Daytime hours	7 hours a day, five days a week
Night and weekend hours	Optional, but encouraged

Lab results notification:

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

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

Access to Care Standards for Visits to Specialists



Blue Cross and Blue Shield of North Carolina HMO-POS-PPO

Waiting time for appointment:

Urgent health need that requires care within 24 hours

Pediatrics	see within 24 hours
Adults	see within 24 hours

For regular appointments

Pediatrics	within 2 weeks (example: tube referral)
Adults	within 2 weeks for a sub-acute problem, i.e., general or nonspecific symptoms, that requires a short office visit. Within 4 weeks for a chronic problem that requires a longer consultation time.

Time spent in waiting rooms:

For a scheduled appointment	After 30 minutes, the patient must be given an update on waiting time with an option of waiting or rescheduling the appointment. The maximum acceptable waiting time is 60 minutes.
Work-ins (Patient called that day prior to coming)	After 45 minutes, the patient must be given an update on waiting time with an option of waiting or rescheduling. The maximum waiting time is 90 minutes.

Response time for returning calls after hours:

For an Urgent* Need	20 minutes
For a Nonurgent Need	1 hour

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

Office Hours – indicates hours during which appropriate personnel is available to care for members, i.e., MD, DO, FNP, PA.

Daytime office hours	Minimum of 15 hours per week covering at least 4 days a week
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Hours of availability:

Daytime hours	40 hours per week
Night and weekend hours	24-hour coverage

BCBSNC and the Physician Advisory Group have established these Access to Care Standards for primary care physicians and specialists. Please note that these standards are monitored at the practice level, not the individual provider level.

Study: 1 in 6 Has Asymptomatic Eye Disease

Almost one out of six patients who undergoes a routine eye examination in an optometric practice has an asymptomatic eye disease, a recent Canadian study finds. The study, conducted by Barbara E. Robinson, O.D., Ph.D., shows that of 24,570 patients, 13.67 percent were diagnosed with an eye disease, even though they had not complained of any specific symptom.

It's interesting to note that good visual acuity does not rule out the presence of eye disease, as 60 percent of those diagnosed had best-corrected visual acuity of 6 / 7.5 or better. Eye care practitioners have long maintained that regular comprehensive eye examinations are important as a means of detecting eye disease before sight loss can occur. Dr. Robinson believes the study results could prove helpful in demonstrating the importance of regular comprehensive eye care.

BCBSNC Member Rights and Responsibilities



Blue Cross and Blue Shield of North Carolina members have the right to:

- Receive information about their coverage and their member rights and responsibilities.
- Receive, upon request, facts about their plan, including a list of doctors and health care services covered.
- Receive polite service and respect from BCBSNC.
- Receive polite service and respect from the doctors who are part of the BCBSNC network.
- Receive the reasons why BCBSNC denied a request for treatment or health care service, and the rules used to reach these results.
- Receive, upon request, details on the rules used by BCBSNC to decide whether a procedure, treatment, site, equipment, drug or device needs prior approval.
- Receive, upon request, a copy of BCBSNC's list of covered prescription drugs. They can also request updates about when a drug may become covered.
- Receive clear and correct facts to help them make their own health choices.
- Play an active part in their health care and discuss all treatment options with their doctor without regard to cost or benefit coverage.
- Expect that BCBSNC will take measures to keep their health private and protect their health care records.
- Complain and expect a fair and quick appeals process for addressing any concerns they may have with BCBSNC.

BCBSNC members should be responsible for:

- Presenting their ID card each time they receive a service.
- Reading their BCBSNC benefit booklet and all other BCBSNC member materials.
- Calling BCBSNC when they have a question or if the material given to them by BCBSNC is not clear.
- Follow the course of treatment prescribed by their doctor. If they choose not to comply, they should advise their doctor.
- Provide to BCBSNC and their doctors complete information about any illness, accident or health care issues.
- Make appointments for nonemergency medical care and keep their appointments. If it is necessary to cancel an appointment, they should give the doctor's office at least 24 hours notice.
- Play an active part in their health care.
- Be polite to network doctors, their staff and BCBSNC staff.
- Tell their place of work and BCBSNC if they have any other group coverage.
- Tell their place of work about new children under their care or other family changes as soon as possible.
- Protect their ID card from improper use.

Personal Care Plan members should:

- Select and use a primary care doctor.
- Manage most of their care (except OB/GYNs or emergency care) through their primary care doctor.
- Call their primary care doctor within two days of a medical emergency in order to arrange follow-up care using the Personal Care Plan network, unless their primary care doctor and BCBSNC approve other care.

MedPoint members should:

- Select and use a primary care doctor.
- Plan most of their care (except OB/GYNs or emergency care) through their primary care doctor in order to receive in-network benefits.
- Call their primary care doctor within two days of a medical emergency.

Blue Care and Blue Choice members should:

- Comply with rules discussed in their benefit plan booklet.

Facility Standards for Managed Care Physician Practices

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

- 1** The general appearance of the facility must provide an inviting, organized and professional demeanor including, but not limited to, the following:
 - a. The grounds are well maintained; patient parking is adequate with easy traffic flow.
 - b. The waiting area(s) and exam rooms are clean with adequate seating for patients and family members.
- 2** There are clearly marked handicapped parking space(s) and handicapped access to the facility.
- 3** A smoke-free environment is promoted and provided for patients and family members.
- 4** A fire extinguisher is clearly visible and is readily available.
- 5** There is a private area for confidential discussions with patients.
- 6** Health-related materials are available for patients. (examples: patient education, office and insurance information are displayed).
- 7** Designated toilet and bathing facilities are easily accessible and equipped for the handicapped (i.e., grab bars).
- 8** There is an evacuation plan posted in a prominent place or exits are clearly marked and visible.
- 9** Halls, storage areas, and stairwells are neat and uncluttered.
- 10** There are written policies and procedures to effectively preserve patient confidentiality. The policy specifically addresses 1) how informed consent is obtained for the release of any personal health information currently existing or developed during the course of treatment to any outside entity, i.e., specialists, hospitals, 3rd party payers, state or federal agencies; and 2) how informed consent of release of medical records, including current and previous medical records from other providers which are part of the medical record, is obtained.
- 11** Restricted, biohazard, or abusable materials (i.e., drugs, needles, syringes, prescription pads, and patient medical records) are secured and accessible only to authorized office/medical personnel. Archived medical records and records of deceased patients should be stored and protected for confidentiality.
- 12** There is a dedicated emergency kit available that includes sufficient equipment/supplies to support life until a patient can be moved to an acute care facility. (at a minimum, site must have an ambu bag and airway).
- 13** There is a written procedure that is in compliance with state regulations for oversight of mid-level practitioners.

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Blue Advantage Generics



Blue Advantage[®], Blue Cross and Blue Shield of North Carolina's individual member PPO product, now has an expanded benefit with greater coverage for generic medications. Starting in 2002, generic prescriptions will no longer be limited by the prescription drug benefit maximum. This means that Blue Advantage members can stretch their prescription drug benefits by electing to receive generics whenever possible. Members will not only save on out-of-pocket expenses because generics are offered at a lower copayment, but it could also help them avoid reaching their prescription drug maximum.



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