BlueLINK℠

News from Blue Cross and Blue Shield of North Carolina

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For articles specific to your area of interest, look for the appropriate icon.

- (P) Physicians
- (F) Facilities/Hospitals
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BlueCross BlueShield of North Carolina

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Are You Ready for HIPAA?

(P) (F) (A) (Rx)

Did you know that new transaction and code set standards will be effective in less than a year and a half? Are you ready? If not, you should strongly consider completing a compliance plan to request your Health Insurance Portability and Accountability Act (HIPAA) extension.

The standards apply to any entity that transmit health information (claims, eligibility inquiries, authorizations, etc.,) in electronic format. We at Blue Cross and Blue Shield of North Carolina (BCBSNC) are encouraging all health care providers and health care clearinghouses to join us in filing for an extension, so we can work with you to ensure a smooth transition to the new standards by October 16, 2003.

How to File a HIPAA Compliance Plan Extension

The Department of Health and Human Services (DHHS) has approved a one-year extension for compliance with the Electronic Health Care Transactions and Code Sets Standards mandated by the HIPAA Act of 1996. **Providers are responsible for filing their compliance plan extensions through the Centers for Medicaid and Medicare Services (CMS) no later than October 16, 2002, which is the current effective date for the Transactions and Code Sets Standards.**

Compliance plans must be filed before October 16, 2002, in order to obtain an extension. For details on completing your compliance plan, please contact the Centers for Medicare and Medicaid Services (CMS) Web site at ***www.cms.gov/hipaa***. They may also be reached by phone at **1-410-786-3000**.

For general HIPAA information, you may contact the North Carolina Healthcare Information and Communications Alliance Web site at ***www.nchica.org*** or the Department of Health and Human Services site at ***www.hhs.gov***.

Integration of BCBSNC and PARTNERS Network Management Staff

(P) (F) (A) (Rx)

You may have heard that provider-servicing functions for BCBSNC and PARTNERS have been combined under a single administrative structure, as was done recently for our respective provider contracting functions. As of March 2002, PARTNERS Network Management staff has been incorporated into the BCBSNC Network Management team. You will still contact a PARTNERS representative for questions related to PARTNERS administrative policies and procedures, including claims processing issues.

(Please see Integration of BCBSNC and PARTNERS)

Integration of BCBSNC and PARTNERS (continued)

PARTNERS' membership will begin migration to BCBSNC products and platforms as of January 1, 2003. PARTNERS existing contractual terms will remain in place until the migration is complete.

Combining network management contracting and service functions is consistent with our previously announced decision to fully integrate the BCBSNC and PARTNERS organizations. This will allow us to take full advantage of the Blue Cross and Blue Shield brand and better serve our customers and business partners.

Our Case Managers are Here to Help

Did you know that BCBSNC has 35 registered nurse case managers available to assist you with your patients' needs? Our case managers can provide additional education to your BCBSNC patients regarding their diagnosis, treatment plan, medications, even community resources that can be of help to them.

Patients are assigned their own personal case manager and have the opportunity to establish a one-to-one rapport with someone who can help them navigate their way through the health care system. We want to help patients better understand their medical condition and/or treatment plan, so that they will be empowered with the knowledge and support they need in order to make the best choices for themselves and their family.

Help us help you provide better patient satisfaction and compliance with your medical treatment plan. Contact Intensive Case Management at **1-800-672-7897** for further information.

When Should a Copayment Be Taken

If a BCBSNC HMO or POS member is at your office for a doctor's visit, surgical care, evaluation and management, or short-term rehabilitative therapy, then a copayment applies and should be collected from the patient.

(continued)

Copayment Be Taken (continued)

If a BCBSNC HMO or POS member is only coming in for diagnostic services, such as lab work, injections (immunizations, allergy shots), and there is no actual visit with a doctor, physician's assistant, or nurse practitioner, then a copayment is not necessary and should not be requested from the patient.

Alpha Prefixes Drive the Claim

If there is an alpha prefix on your BCBS patient's ID card, it's important for you to know how critical that information is when verifying eligibility or getting a claim processed in a timely manner. Please enter the ID number exactly as it appears on the ID card or electronic eligibility files, like Blue *e*.

Just as important to remember is that if the BCBS patient's ID card does not show any alpha prefix or numerical suffix, please don't fill in those fields on the claim form. Doing so can result in delays in processing the claim or possible denial of services due to incorrect member information.

Alpha Prefixes At a Glance

Here's a handy chart to help you know what to look for:

PRODUCT	APLHA PREFIX
Personal Care Plan℠1	YPL
Blue Care®	YPH
Med*Point* ℠1	YPA
Blue Choice,®	YPS
Preferred Care,® CostWise,[1]	YPA
Preferred Care,® *Select*	YPB or YPN
Preferred Care,® *Select Copay*	YPB or YPN
Blue Options℠	YPP
Classic Blue,®	YPM
BlueCard,®	Alpha Prefix does not begin with YP
State Health Plan	No Alpha Prefix
Federal Employee Program	R

Blue *e* Now Available Via the Internet

Earlier this year, we notified current Blue ***e***℠ customers that we would began transitioning Blue ***e*** to the public Internet during late spring 2002.

Since introduced in 1999, Blue ***e*** had only been accessible via a private extranet. Your requests for Internet access enabled us to make the transition to the Internet this year. Benefits of converting Blue ***e*** to the Internet include:

- **Ease of use**
- **Elimination of annual access fees**
- **Your choice of Internet Service Provider (ISP)**

This conversion is occurring in two phases. The first phase, which occurred during April 2002, provided security enhancements to current access controls.

Pilot Phase II Now in Progress

Phase II began in May 2002, when a group of sites piloted Blue ***e*** Internet access with the following new URL address: ***https://blue-edi.bcbsnc.com***. Previously, customers had to secure their own access to the Internet. Completion of Phase II is scheduled for late summer 2002.

Although the transition is not complete, we can provide Blue ***e*** access to new customers via the Internet. With Blue ***e***, health care providers can do the following:

- Search for a patient's certificate number by name.
- Obtain information on health & dental eligibility for BCBSNC and State Health Plan members.
- Verify North Carolina Medicaid eligibility.
- View status of submitted claims, including BlueCard,® claims submitted to BCBSNC.
- View electronic remittance information.
- Enter claims, obtain daily claim listing and correct EDI front-end claims in error.
- View and print EDI bulletins & announcements.

For More Information on Blue *e*

If you would like more information about accessing Blue ***e*** on the Internet, please contact your BCBSNC EDI Services field consultant below:

Tom Taylor	Raleigh Office	919-461-5258
Jason Bradshaw	Hickory Office	828-431-3142
Will Farrish	Charlotte Office	704-561-2751
John Hodges	Greenville Office	252-758-1869
Ann Marie Dillon	Wilmington Office	910-509-0605
Anne Ouellette	Asheville Office	828-684-7168
Beverly Williams	Greensboro Office	336-316-5346

Effective July 1st: Benefit Changes for New and Renewing Groups

Effective July 1, 2002, we are implementing a benefit change–for new groups or at the time of renewal for our existing groups–who are on our Blue Care, (HMO) and Blue Choice, (POS) products. Professional services performed on an inpatient or outpatient basis in a hospital or other facility, such as a skilled nursing facility, will be subject to deductible and coinsurance. Currently, these services are paid at 100 percent of allowable charges. This benefit change does not impact services performed in a doctor's office. These professional services will continue to be subject to the member's copayment only.

However, this change *does* impact maternity benefits. All related charges for maternity care, including pre-natal care, delivery and post-partum care will continue to be bundled together and considered as a global charge at the end of the pregnancy. These professional services will be subject to deductible and coinsurance for new groups with an effective date of July 1, 2002, or after, and for groups renewing with us beginning July 1, 2002.

There are a few exceptions. Services that will not be subject to deductible and coinsurance include diagnostic services not performed with other types of services and ER professional services. Both of these services will be covered at 100 percent when received in-network.

Vision Care Changes for NC Health Choice

Prior approval is no longer necessary for lenses, contacts or frames for children covered under NC Health Choice. One pair of lenses may be provided annually and new frames every two years. Polycarbonate lenses (CPT code V2199) are payable for children up to age 6, or for children who are legally blind or have a medical condition that results in frequent trauma or falls.

If a child experiences a rapid change in vision or additional benefits are needed, prior approval will need to be obtained by calling the State Health Plan Customer Service department at ***1-800-422-4658***.

Recent Changes to Vision Care Services

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

One major change is that routine eye exams are covered at any participating provider that performs this service, which is different from the way OptiCare Eye Health Network, Inc. handled eye exams. It's important to note that the routine eye examination benefit excludes contact lens fitting and fitting for glasses or other hardware.

Most Blue Care, Blue Choice, Blue Options, Personal Care Plan and Med*Point* members pay a standard $10 copayment for routine vision exams at network provider locations. Member ID cards that contain the word "VISION" indicate that annual routine exams are covered benefits.

Eyewear and Contact Lens Discounts

Providers participating in all product lines – HMO, POS, PPO, CMM - that own optical dispensaries are giving BCBSNC patients a 30 percent prescription eyewear discount, as well as a 15 percent discount on disposable contacts. All BCBSNC members are eligible for the discounts, with the exception of State Health Plan and Federal Employee Program members. ID cards do not reflect the discount information, as the discounts are not covered benefits.

We also offer employer groups an optional Lens and Frames Rider, which is separate from the discount vision program. If a group has elected to offer this rider, those BCBSNC members must pay for lenses and frames or contacts, less the discount, at the time of service. Then, those members will submit a BCBSNC member claim form to us for reimbursement up to the benefit period maximum.

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

BlueCross BlueShield of North Carolina

RealMed Proves Value to BCBSNC Physicians

Blue Cross and Blue Shield of North Carolina (BCBSNC) and RealMed Corporation (RealMed) are pleased to announce the addition of several area physician groups to the list of RealMed Health™ (RMH) users.

Contracted BCBSNC physician offices who use RealMed Health can immediately determine patient eligibility, review up-to-the-minute copayment and deductible information, resolve patients' claims in seconds at the point-of-service (including front-end and back-end error checks), receive and print the patient's Explanation of Benefits (EOB), and collect any balance due from the patient–all within minutes following a patient visit with the physician. In recent weeks, Piedmont HealthCare and Piedmont Ear, Nose, and Throat have begun the process of introducing RealMed technology into their physician practices.

Characteristics of a RealMed Office

In order to be successful in installing RMH, a physician office needs to have the following general characteristics – a BCBSNC claim volume of at least 500 claims per month, a practice management system that is integratable to RealMed (including but not limited to any of the following: Medic, Medical Manager, IDX, Kredo or MIMs), and hardware and technical infrastructure within the office that includes Internet access, PC workstations and a high-speed modem. Most importantly, potential RealMed users should have a willingness and ability to invest resources, advocate for change to process and workflows, and champion the use of RealMed technology within their office.

RealMed and Blue e Work Together

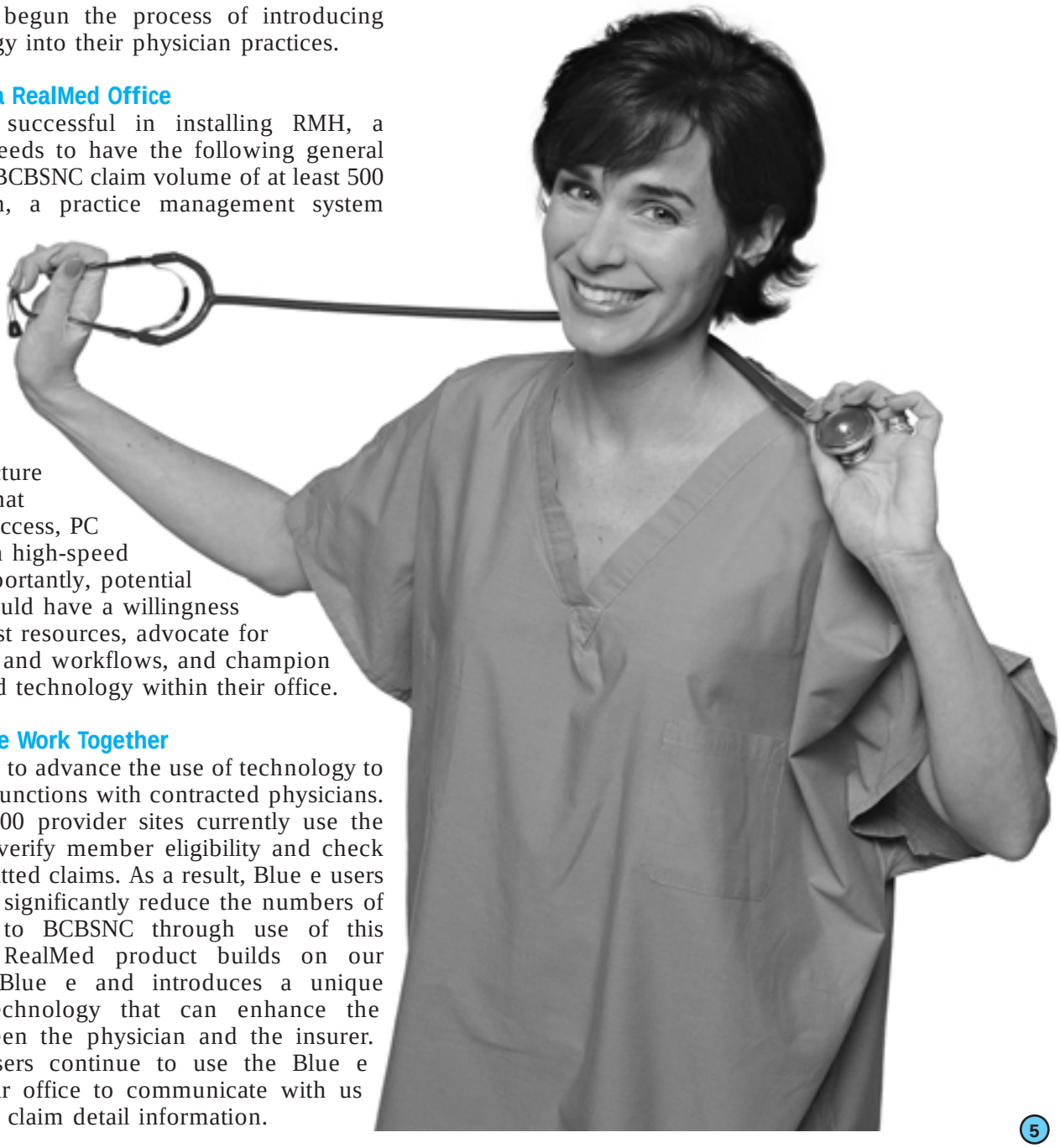
BCBSNC continues to advance the use of technology to perform business functions with contracted physicians. Approximately 1,400 provider sites currently use the Blue e system to verify member eligibility and check the status of submitted claims. As a result, Blue e users have been able to significantly reduce the numbers of calls they make to BCBSNC through use of this technology. The RealMed product builds on our experience with Blue e and introduces a unique component of technology that can enhance the relationship between the physician and the insurer. Many RealMed users continue to use the Blue e application in their office to communicate with us regarding in-depth claim detail information.

Would You Like to Learn More About RealMed?

BCBSNC and RealMed staff are available to make presentations to interested physician groups. To arrange a presentation for your practice, log onto the RealMed Web site at ***www.realmed.com***, and complete the provider survey. Your confidential data will be used to plan a targeted sales call to your office during which the value of using the RealMed system will be demonstrated to you and your physicians.

Stay tuned to Blue Link for more information on RealMed and special opportunities for viewing the technology.

TM RealMed Health is a trademark of the RealMed Corporation.



Notify BCBSNC When You Join or Leave a Practice

We want to make sure you are aware that you are contractually required to notify BCBSNC within a specific time frame when joining or leaving a group*. Notify your local BCBSNC Network Management office in writing at least 90 days prior to the change. Here's the information they will need from you:

- **Your name and individual provider number**
- **Name, address, phone number, and group provider number of the practice that you are leaving**
- **Name, address, phone number, and group provider number of the practice you are joining**
- **The date of the change**

Effective April 1, 2002, we began recognizing both the individual provider number and the group provider number for claims adjudication purposes. Keeping your information up-to-date with us is critical, because claims for providers who are not covered by the group's contract will process at the out-of-network level and cannot be billed to the member.

After you notify us that you are joining a new group, your credentialing status will be verified, an effective date assigned, and your provider name and number will be loaded into our system. At that time, you will be covered by the new group's contract, and the practice is notified in writing of your effective date on our system. Beginning on the assigned effective date, claims for services you render will be processed at the in-network level. Please contact your local Network Management office if you have any additional questions.

**If you also contract with PARTNERS, you will need to notice them directly, as their claims system is still separate from BCBSNC.*

Updates on Our New Injectable Drug Network

An injectable drug network is now available to supply you with select injectable drugs for the treatment of your BCBSNC patients*. This network only applies to those injectable drugs that require the supervision of a health care professional.

The goals of the program are to:

- Improve access to and simplify the process of obtaining select injectable drugs.
- Streamline the submission of injectable drug claims.
- Provide a cost-effective service to you and our members.

Use of the Network Is Voluntary

OptionMed is the initial pharmaceutical vendor for this network. Their toll-free number is ***1-800-720-7522*** and toll-free fax number is ***1-888-594-8981***. You can order member-specific injectable drugs from OptionMed and have them shipped to your office. Orders will be accepted up to seven days prior to the patient's appointment. Delivery is guaranteed and most orders will be delivered within 24 to 48 hours.

The vendor will bill BCBSNC directly for the injectable drug – reducing time and paperwork for your office, as well as removing the financial risk you may have encountered when supplying injectable drugs to patients in the past. We are continuing to evaluate the addition of other vendors to the network. You can find more information about the program, including any additional vendors, in the Provider section of our Web site at ***bcbsnc.com***.

If you have general questions about the program, please contact your local BCBSNC Network Management office. For questions specific to ordering injectable drugs, please contact the vendor.

**Please note that Medicare Supplement subscribers, Federal Employee Program and North Carolina State Health Plan members are excluded. Please continue to obtain injectable drugs for these patients through your current process.*

BCBSNC Offers New Migraine Care Program

We are pleased to announce the introduction of a migraine headache care initiative designed to support diagnosis and appropriate management as part of the Your Healthy Best® health management program. As part of this program, BCBSNC members who suffer from migraine headaches will receive comprehensive educational materials, a headache diary, and personalized support from registered nurses to help complement the care they currently receive from you, their physician.

Rather than relying on their primary care physician, many migraine sufferers often seek treatment in the emergency room. This often results in repeated and/or unnecessary testing or procedures. Many people with migraine have the mistaken belief that they have sinus headache or stress/tension headache. Over 50 percent of migraine sufferers are inaccurately diagnosed. Additionally, many migraine sufferers continue on outdated treatment approaches that have limited efficacy for migraine or troublesome side effects. Some may even overuse narcotics and other pain-killing drugs, which can lead to dependency, addiction, or rebound headache.

Managing Migraine Info Packet Available

Consequently, migraine sufferers have a higher tendency for poor clinical outcomes, dissatisfaction with care, and a higher than necessary cost of care. Upon request, BCBSNC can supply you with an informational packet on the "Standards of Care for Headache Diagnosis and Treatment" as established by the National Headache Foundation, along with Migraine Clinical Care Path pocket cards, a migraine patient counseling guide, tip sheets on the biology of migraine, information on the use of diagnostic technology, ways to optimize pharmacotherapy, and tips to share with patients on how to avoid rebound headache.

If you would like a packet or need more information on the migraine care initiative or other conditions addressed by the Your Healthy Best program, please call us at ***1-800-218-5295, ext. 1303***. You can also refer BCBSNC patients to the program via our Web site at ***bcbsnc.com***.

Screen Patients for Pre-Diabetes

A workgroup convened by the American Diabetes Association and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health (NIH), recently recommended that health care providers across America begin screening people at risk for diabetes for a serious condition referred to as "pre-diabetes." Screening should be carried out as part of a routine health care office visit.

The workgroup's recommendations stem from an analysis of NIDDK's Diabetes Prevention Program and other recent major prevention studies. The studies found that people with pre-diabetes could prevent or delay onset of type 2 diabetes by up to 58 percent through modest weight loss and physical activity.

Who's at Risk?

If a person is overweight and age 45 or older, they should be tested for pre-diabetes during their next routine office visit. If a patient's weight is normal and they're over age 45, you should decide if testing is warranted.

For adults who are obese and younger than 45, testing is recommended if they have any other risk factors for diabetes or pre-diabetes. Risk factors include: high blood pressure, high cholesterol, a family history of diabetes, a history of gestational diabetes or giving birth to a baby weighing more than 9 lbs., or belonging to an ethnic or minority group at high risk for diabetes.

It's important to counsel those patients with pre-diabetes to increase their physical activity and lose weight. The level of activity and weight loss recommended is modest, such as 5-10 percent loss of body weight and 30 minutes of physical activity daily. Patients should be monitored for the development of diabetes every one to two years.

Preventive Care Guidelines*

BlueCross BlueShield of North Carolina

Goals

- **Prevent the onset of targeted conditions**
- **Identify and treat asymptomatic patients who have risk factors or preclinical disease but in whom the condition has not become clinically apparent**
- **Establish a consistent assessment schedule and indicators**
- **Monitor the health and medical needs of the patient**
- **Provide education and recommended screening and interventions to the patient/parent**
- **Reassure the patient/parent**
- **Assess the patient's well-being**
- **Detect medical and psychosocial complications and institute indicated interventions**

Guideline Precedent

Based on Preventive Health Services Policy (1990 to 1997)

Key Process and Outcome Measures

Effectiveness of Care**

- **Childhood Immunizations:** (Children turning two years of age during the reporting year)
- **Adolescent Immunizations:** (Children turning 13 years of age during the reporting year)
- **Cervical Cancer Screening:** (Women age 21 through 64 years as of the end of the reporting year)
- **Breast Cancer Screening:** (Women age 52 through 69 years as of the end of the reporting year)
- **Advising Smokers to Quit:** (Adults 18 and older as of the end of the reporting year)
- **Controlling High Blood Pressure:** (Adults 46 through 85 years old as of the end of the reporting year)
- **Beta Blocker Treatment After a Heart Attack:** (Adults 35 years and older as of the end of the reporting year)
- **Cholesterol Management After Acute Cardiovascular Events:** (Adults 18 through 75 years old as of the end of the reporting year)
- **Comprehensive Diabetes Care:** (Adults 18 through 75 years old as of the end of the reporting year)
- **Use of Appropriate Medications for People with Asthma:** (Members 5 through 56 as of the end of the reporting year)
- **Antidepressant Medication Management:** (Adults 18 years and older as of the 120th day of the reporting year)
- **Follow-Up After Hospitalization for Mental Illness:** (Members 6 years and older as of the end of the reporting year)
- **Flu Shots for Older Adults:** (Adults 65 and older as of the beginning of the reporting year)

Use of Services

- **Well-Child Visits in the First 15 Months of Life**
- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life**
- **Adolescent Well-Care Visits**

Informed Health Care Choices

- **Management of Menopause:** (Women age 47 through 55 as of the end of the reporting year)

Sources

Advisory Committee on Immunization Practices (http://www.cdc.gov/nip/acip)

American Academy of Family Physicians (http://www.aafp.org)

American Academy of Pediatric Dentistry (http://www.aapd.org)

American Academy of Pediatrics (www.aap.org)
(Report of the Committee on Infectious Diseases of the American Academy of Pediatrics (The Red Book), 2000)

American Cancer Society (http://www.cancer.org)

American Medical Association (http://www.ama-assn.org)

Centers for Disease Control (http://www.cdc.gov)

National Center for Education in Maternal and Child Health (http://www.ncemch.org)

National Osteoporosis Foundation Physician's Guide to Prevention and Treatment of Osteoporosis (http://www.nof.org)

North Carolina Department of Health and Human Services (http://www.dhhs.state.nc.us)

North Carolina General Statutes

U.S. Preventive Services Task Force (http://odphp.osophs.dhhs.gov/pubs/guidecps/)
(Guide to Clinical Preventive Services, Report of the US Preventive Services Task Force, 3rd ed., 2000-2002)

*These guidelines are subject to the limitations of the member's preventive care benefits.
** See National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) website for complete descriptions of Effectiveness of Care Measures: http://www.ncqa.org

Origination Date: July 1, 1998
Updated – 10/98, 2/99, 12/99, 1/01, 3/02

Preventive Care For Infants to 24 Months

Detection Intervention

- Six office visits during first year for routine health assessment
- Three office visits during months 13-24 for routine health assessment

First Week

	Service	Schedule
All Infants[1]:	Ocular prophylaxis	No later than one hour after birth: Erythromycin 0.5% ophthalmic ointment, tetracycline 1% ophthalmic ointment, or 1% silver nitrate solution should be applied topically to the eyes of all newborns
	Phenylketonuria screening	Before discharge from nursery
	Hypothyroidism screening	Before discharge from nursery
	Galactosemia screening	Before discharge from nursery
	Sickle cell screening	Before discharge from nursery
	Congenital adrenal hyperplasia screen	Before discharge from nursery
High Risk Groups:	Hearing[2]	Before discharge from nursery; those not tested at birth should be screened before age 3 months

Routine Visit

	Service	Schedule
All Infants:	History and physical exam (including height and weight)	Six visits during first year; three visits during second year.
	Height, weight and head circumference	Every visit
	Developmental/behavioral assessment	Every visit
	Anticipatory guidance for parent (including diet, injury prevention, dental health, effects of passive smoking, sleep positioning counseling)	Every visit
	Fluoride supplement, if appropriate[3]	Daily for children between 6 months to 16 years of age
	Lead screening	Once between 12-24 months of age (or upon first entry to a health care system, if older). All children should be assessed for risk of exposure to lead through administration of a questionnaire at each routine well-child visit between 6-72 months of age.
High Risk Groups:	Hgb/hct[4]	Once during infancy (6-12 months of age)
	Tuberculin skin test (PPD)[5]	At 12 months of age
	Influenza Vaccination[6]	As recommended by physician

1 Newborn screening tests per North Carolina state guidelines. Premature or ill infants should be screened between 24-72 hours of age. Infants tested before the 24th hour of age should receive a repeat screening by one week of age.

2 Risk factors include family history of hereditary childhood sensorineural hearing loss, congenital perinatal infection, malformations of the head or neck, birth weight below 1,500 g, bacterial meningitis, hyperbilirubinemia, and severe perinatal asphyxia.

3 AAPD recommends the supplementation of a child's diet with fluoride when fluoridation in drinking water is suboptimal. Fluoride supplements should be considered for all children drinking fluoride deficient (<0.6ppm F) water.

4 For pre-term, low birth weight, low income, migrant, or infants on principal diet of whole milk.

5 Risk factors include those with household members with disease, recent immigrants from countries where disease is common, migrant families and residents of homeless shelters.

6 Recommended for immunocompetent patients 6 months – 50 years of age with chronic cardiac or pulmonary disease, diabetes mellitus, renal dysfunction, hemoglobinopathies, and those living in special environments or social settings with an identified increased risk of influenza. It is also recommended for persons 6 months – 18 years of age receiving long-term aspirin therapy.

Preventive Care For Infants to 24 Months

Detection Intervention

- Four office visits between ages 2-6 years for routine periodic health assessment
- Office visit every other year for ages 7-10 years for routine periodic health assessment
- Office visit every year for ages 11-18 years for routine periodic health assessment

Routine Visit

	Service	Schedule
All Children/ Adolescents:	History and physical exam[7]	Four visits between ages 2 to 6 years One visit every other year between ages 7 to 10 years One visit every year between ages 11 to 18 years
	Height and weight	At each visit for routine health exam
	Blood pressure (Screening for hypertension)	Sphygmomanometry should be performed at each visit beginning at age 3, in accordance with the recommended technique for children, and hypertension should only be diagnosed on the basis of readings at each of three separate visits.
	Behavioral/developmental assessment	Every visit
	Anticipatory guidance[8]	Every visit
	Fluoride supplement, if appropriate[3]	Daily for children between 6 months to 16 years of age
	Vision screen for amblyopia and strabismus[9]	Recommended for all children once before entering school, preferably between ages 3 and 4 years. Vision screening generally provided by school system ages 7-12.
	Scoliosis (curvature of the spine) screen	During complete physical exams for patients age 13-18 years
	Eating Disorders screen	Every visit for patients age 13-18 years
	Hgb/hct	Annually for menstruating adolescent females
	Hernia/testicular cancer screen	Every visit for male patients age 13-18 years
High Risk Groups:	Hearing[2]	Before age 3 years for high risk children, if not tested earlier.
	Tuberculin skin test (PPD)[5]	As recommended by physician
	Lead screening[10]	Annually
	Pneumoccocal Vaccination[11]	As recommended by physician
	Influenza Vaccination[12]	As recommended by physician
	Cholesterol	One time at age 6 or older when positive family history for early cardiovascular disease or hyperlipidemia; otherwise one test between ages 13 and 18 years
	Papanicolaou smear (Pap test) - Cervical cancer screening	Annually for female patients who are/have been sexually active or have reached age 18

7 AAP guidelines recommend a complete physical exam annually for children 7-18 years of age.

8 For patients to age 12 years, this includes diet, injury and violence prevention, dental health, and effects of passive smoking. For patients age 13-18 years, anticipatory guidance should include diet and exercise, injury prevention, sexual practices and substance abuse. For patients with family history of skin cancer; large number of moles; or fair skin, eyes or hair, guidance should also include skin protection from UV light.

9 Clinicians should be alert for signs of ocular misalignment. Stereoacuity testing may be more effective than visual acuity testing in detecting these conditions.

10 Risk factors include living in or frequently visiting an older home (built before 1950), having close contact with a person who has an elevated lead level, living near lead industry or heavy traffic, living with someone whose job or hobby involves lead exposure.

11 Recommended for immunocompetent patients 24 months – 65 years of age with chronic cardiac or pulmonary disease, diabetes mellitus, anatomic asplenia (excluding sickle cell disease), and those living in special environments or social settings with an identified increased risk of pneumococcal disease.

12 Recommended for immunocompetent patients 6 months – 50 years of age with chronic cardiac or pulmonary disease, diabetes mellitus, renal dysfunction, hemoglobinopathies, and those living in special environments or social settings with an identified increased risk of influenza. It is also recommended for women in their second or third trimester of pregnancy during influenza season and for persons 6 months – 18 years of age receiving long-term aspirin therapy.

BlueCross BlueShield of North Carolina

Preventive Care For Adults, 19-64 Years Old

Detection Intervention

- Office visit every 1-3 years which includes assessment, routine testing and education

Routine Visit

	Service	Schedule
All Adults:	History and physical exam	Every 1 to 3 years until age 40, and then annually
	Height and weight	Every visit
	Blood pressure - screening for hypertension	Every 1 to 3 years
	Tetanus and diphtheria Immunization	Every 10 years
	Diet & exercise counseling	Every 1 to 3 years
	Tobacco, Alcohol, and Substance Abuse Counseling	Every 1 to 3 years
	Sexual practices counseling	Every 1 to 3 years
	Eye exam	Every 1 to 3 years until age 40, and then annually
	Total blood cholesterol (can be non-fasting)	Every five years, if normal
	Influenza vaccination	Annually for age 50 and older
	Colorectal cancer screening	One of the following screening tests is recommended for age 50 and older: - Annual fecal occult blood test (FOBT) - Flexible sigmoidoscopy, every five years - Annual FOBT and flexible sigmoidoscopy, every five years - Total colon examination by DCBE, every 5-10 years - Total colon examination by colonoscopy, every 10 years
	Hormone prophylaxis counseling	Every visit for peri- and post-menopausal women
	Osteoporosis prevention counseling	Every visit for peri- and post-menopausal women
	Papanicolaou smear (Pap test) - Cervical cancer screening	Annually for women (less frequent testing is permitted once three or more annual smears have been normal and if recommended by the physician)
	Clinical breast exam	Annually for women age 19-and older (more frequently for women with a family history of pre-menopausally diagnosed breast cancer)
	Mammogram - Breast cancer screening	Women who have not had bilateral mastectomy: - One baseline screening for women age 35-39 - One screening annually for women age 40 and older
High Risk Groups:	Digital Rectal Exam - Prostate cancer screening[13]	As recommended by physician for men considered to be at risk for prostate cancer
	Prostate-specific antigen (PSA)[13]	As recommended by physician for men considered at risk for prostate cancer
	Tuberculin skin test (PPD)[5]	Every 1 to 3 years
	Pneumoccocal vaccination[11]	As recommended by physician
	Influenza vaccination[12]	As recommended by physician
	Testing for sexually transmitted disease (including HIV)[14]	As recommended by physician
	Electrocardiogram (ECG)[15]	As recommended by physician
	Bone mineral density screening[16]	Initial screening for postmenopausal women at risk for osteoporosis; subsequent screenings should be based on risk status

13 Risk factors include: family history of prostate cancer, age (risk increases beginning at ages 55-60), being of African-American descent, consuming a high-fat diet, having had a vasectomy

14 Risk factors include history of prior STD, new or multiple sex partners, inconsistent use of barrier contraceptives, use of injection drugs

15 Recommended for patients with two or more of the following risk factors: family history of heart disease, smoking, high cholesterol, diabetes, or hypertension

16 Refer to the BCBSNC Medical Policy: Bone Mineral Density Studies at www.bcbsnc.com

Preventive Care The Elderly, 65 Years and Older

Detection Intervention

- Office visit annually which includes assessment, routine testing and patient education

Routine Visit

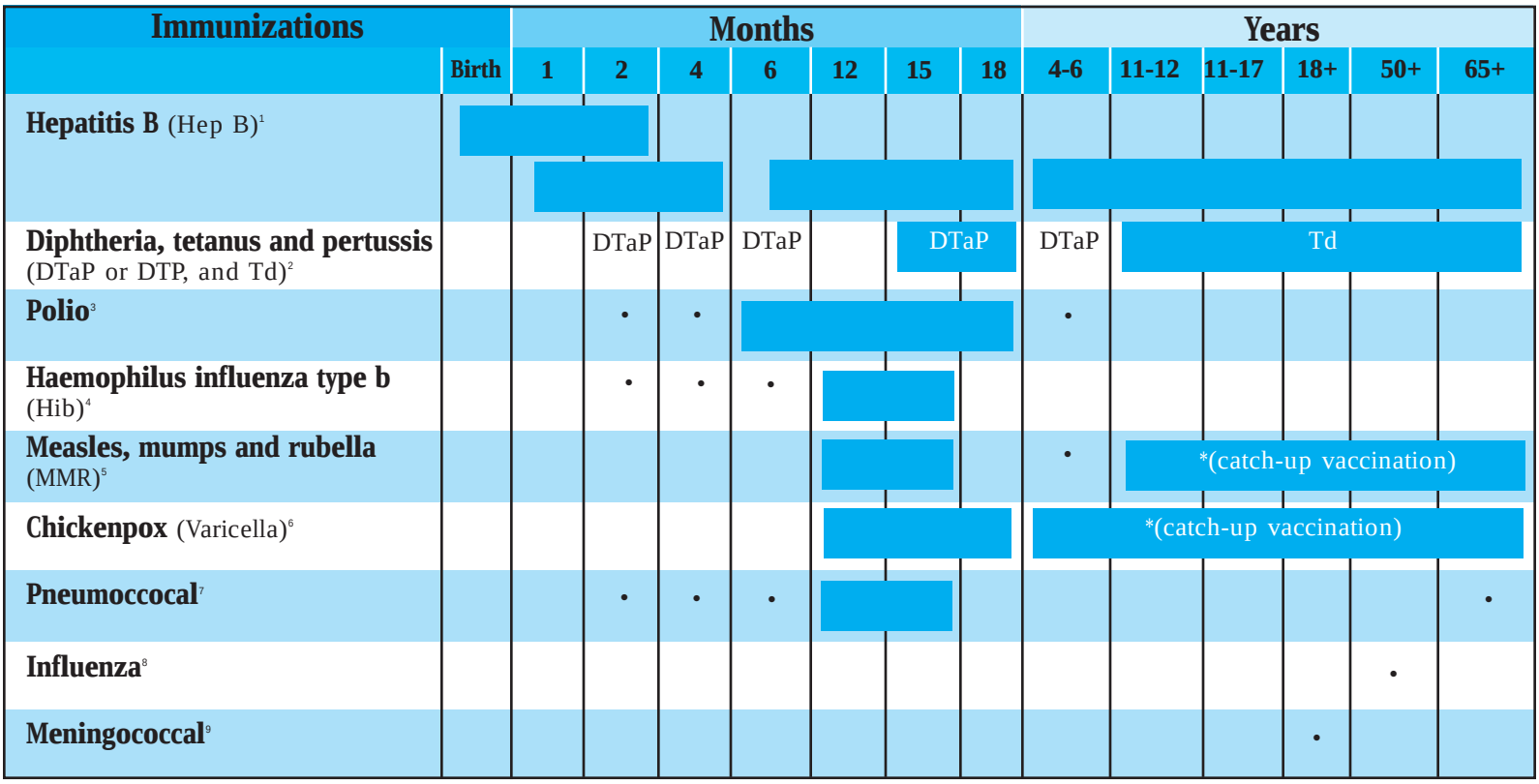
	Service	Schedule
	History and physical exam	Annually
	Blood pressure (screening for hypertension)	Annually
	Diet & exercise counseling	Annually
	Tobacco, Alcohol, and Substance Abuse counseling	Annually
	Sexual practices counseling	Annually
	Total blood cholesterol (can be non-fasting)	Annually
	Vision screen and Hearing test	Annually, as recommended by physician. Periodically question patients about hearing, counsel about hearing aid devices, and make referrals for abnormalities.
	Colorectal Cancer Screening	One of the following screening tests is recommended: - Annual fecal occult blood test (FOBT) - Flexible Sigmoidoscopy, every five years - Annual FOBT and Flexible Sigmoidoscopy, every five years - Total colon examination by DCBE, every 5-10 years - Total colon examination by colonoscopy, every 10 years
	Influenza Vaccination	Annually
	Pneumoccocal Vaccination[17]	Once if patient has not already received
	Hormone prophylaxis counseling	Annually for post-menopausal women
	Osteoporosis prevention counseling	Annually for post-menopausal women
	Papanicolaou smear (Pap test) - Cervical cancer screening	Annually, as recommended by physician, for women who are/have been sexually active and who have a cervix. May discontinue if previous regular testing results were consistently normal.
	Clinical Breast exam	Annually for women
	Mammogram - Breast cancer screening	Annually for women who have not had a bilateral mastectomy
High Risk Groups:	Digital Rectal Exam - Prostate cancer screening[13]	As recommended by physician for men considered to be at risk for prostate cancer
	Prostate-specific antigen (PSA)[13]	As recommended by physician for men considered to be at risk for prostate cancer
	Tuberculin skin test (PPD)[5]	As recommended by physician
	Testing for sexually transmitted disease (including HIV)[14]	As recommended by physician
	Bone Mineral Density Screening[16]	Initial screening for postmenopausal women at risk for osteoporosis; subsequent screenings should be based on risk status
	Electrocardiogram (ECG)[15]	As recommended by physician

17 Persons vaccinated prior to age 65 should be vaccinated at age 65 if five or more years have passed since the first dose. For all persons with functional or anatomic asplenia, transplant patients, patients with chronic kidney disease, immunosuppressed or immunodeficient persons, and others at high risk of fatal infection, a second dose should be given – at least five years after first dose.

BlueCross BlueShield of North Carolina

Routine Immunizations

The following immunization schedule incorporates recommendations from the American Academy of Family Physicians, the North Carolina Department of Health and Human Services, the American Academy of Pediatrics, and the Centers for Disease Control's Recommended Childhood Immunization Schedule, 2002.



*Catch-up Vaccinations – indicates age groups that warrant special effort to administer those vaccines not previously given

1 All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge. The first dose may also be given by age 2 months if the infant's mother is HBsAg-negative. Only monovalent hepatitis B vaccine can be used for the birth dose. Monovalent or combination vaccine containing Hep B may be used to complete the series; four doses administered if combination vaccine is used. The second dose should be given at least 4 weeks after the first dose, except for Hib-containing vaccine which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 6 months.

Infants born to HbsAg-positive mothers should receive hepatitis B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1-2 months and the vaccination series should be completed (third or fourth dose) at age 6 months.

Infants born to mothers whose HbsAg status is unknown should receive the first dose of the hepatitis B vaccine series within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HbsAg status; if the HbsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week).

2 The 4th dose of DTaP (diptheria and tetanus toxoids and acellular pertussis vaccine) may be administered as early as 12 months of age, provided 6 months have elapsed since the 3rd dose and the child is unlikely to return at age 15 to 18 months. Td (tetanus and diptheria toxoids) is recommended at 11 to 12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every 10 years.

3 An all-IPV schedule is recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at 2 months, 4 months, 6-18 months, and 4-6 years of age.

4 Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. DtaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4, or 6 months, but can be used as boosters following any Hib vaccine.

5 The second dose of measles, mumps, and rubella (MMR) vaccine is recommended routinely at 4 to 6 years of age but may be administered during any visit, provided at least four weeks have elapsed since receipt of the first dose and that both doses are administered beginning at or after 12 months of age. Those who have not previously received the second dose should complete the schedule by the 11 to 12-year-old visit.

6 Varicella vaccine is recommended at any visit or after age 12 months for susceptible children, i.e. those who lack a reliable history of chickenpox. Persons aged ≥ 13 years without a reliable history of varicella disease or vaccination, or who are seronegative for varicella should receive two doses, given at least 4 weeks apart.

7 The heptavalent conjugate pneumococcal vaccine (PCV) is recommended for all children 2-23 months of age. It is also recommended for certain persons 24 months-59 months of age with chronic illness. Pneumococcal polysaccharide vaccine (PPV) is recommended in addition to PCV for certain high-risk groups.

8 The influenza vaccine is recommended for certain persons 6 months-50 years of age with chronic illness and for those considered at high risk for influenza. Children aged £ 12 years should receive vaccine in a dosage appropriate for their age (0.25 mL if age 6-35 months or 0.5 mL if aged ≥ 3 years). Children aged £ 8 years who are receiving influenza vaccine for the first time should receive two doses separated by at least 4 weeks.

9 Recommended for entering college students, particularly those living in or planning to live in dormitories and residence halls.

Primary Care Providers Improve Continuity of Care

Good continuity and coordination of patient care has been shown to be associated with a variety of positive outcomes, including patient satisfaction, compliance with medication regimens, and appropriate preventive health services utilization. Continuity of care has also been associated with reduced ER visits and lower rates of hospitalization[1]. Because of its impact on health outcomes and the quality of care delivered to patients, BCBSNC systematically monitors relevant data for continuity and coordination of health care services in order to identify opportunities to improve and to develop appropriate interventions to address problems or gaps in the system.

Survey Says...

Previous monitoring efforts have shown that rates of inter-office continuity have been consistently lower than those for other dimensions of continuity. To explore possible barriers to good inter-office continuity, BCBSNC designed and implemented the Provider Continuity Satisfaction Survey in 2001. This survey assessed primary care provider (PMD) satisfaction with the continuity and coordination of care occurring between their practices and consulting specialists, home health agencies, skilled nursing facilities, hospitals, ambulatory surgical centers, and behavioral specialists. The sampling frame included the 884 primary care practices in the BCBSNC network scheduled for re-credentialing medical record reviews in 2001. Of the 884-targeted practices, 251 (28.4 percent) returned surveys.

Number 1 Issue: Timeliness of Sharing Consult Notes

Overall, results of the survey corroborate BCBSNC medical record review data on inter-office continuity that suggests there are opportunities to improve continuity between provider practices. One specific area is improving the timeliness of primary care physicians' receipt of consult notes from consulting and ancillary providers. While 38.3 percent of PMDs indicated that they were very satisfied with timeliness of receipt, the majority of providers expressed that they were somewhat satisfied (52.8 percent); 8.1percent were somewhat dissatisfied, and 0.9 percent were very dissatisfied. Findings also indicate that regardless of the provider type with whom a PMD is coordinating care, PMDs want consult notes sooner than they are receiving them. In general, most PMDs preferred to receive consult notes within two weeks. However, the majority of PMDs preferred to receive notes in less than one week from hospitals and home health agencies. Suggested ways to reduce the response time include transitioning to electronic medical records and/or using other automated systems to house patient information, or using fax machines to send consult notes.

A measure of how comfortable PMD's feel that they have knowledge of all the prescription medications their patients are taking revealed that only about a third of BCBSNC providers feel very comfortable with this coordination. Finally, PMDs reported that they prefer fax as the communication method of choice between providers, followed closely by mail, combined with the use of the telephone to communicate time-sensitive information.

BCBSNC would like to thank those practices that took the time to participate in the survey, as this feedback provides an important source of data in helping guide future planning and quality improvement efforts directed toward improving the process of inter-office continuity and coordination of care. If you would like to provide additional input on ways to improve inter-office continuity, or if you have questions about the Provider Continuity Satisfaction Survey, please send an e-mail to us at ***quality@bcbsnc.com***.

1 Love, M., Mainou, III, A, Talbert, J., & Hager, G. "Continuity of Care and the Physician-Patient Relationship," Journal of Family Practice, Nov. 2000, 998-1016.

BlueCard Makes Improvements in Coordination of Benefits

Along with all other BlueCard Plans across the U.S., BCBSNC is implementing HIPAA compliant software, which will help us process provider claims more efficiently. The new software enables us to process all claims involving coordination of benefits (COB) through the BlueCard program. Previously, some Home Plans had to handle claims directly when COB was involved.

You can now expect payment through the BlueCard program on claims involving COB. Continue to file all BlueCard claims to BCBSNC via normal channels. If you have questions about the BlueCard program, call us at ***1-800-487-5522***.

BlueCard POS Now Available for New Jersey State Retirees

New Jersey State Health Benefits Program Retirees who select the NJ PLUS product will be eligible to enroll under BlueCard Point-of-Service (POS) effective July 1, 2002. BlueCard POS is for members who are actually enrolled in North Carolina's Blue Choice network and primary physician panels.

Treat BlueCard POS members the same as you would treat any other local Blue Choice member and apply the same certification process and network protocols. You can recognize these members by the three-character alpha prefix "NJP" preceding the member ID number and the local Blue Choice network identifier.

Medication Safety Program for Patients Taking Multiple Prescriptions

Here at BCBSNC, we are committed to the health, safety, and wellness of our members. It is with this commitment in mind that we have implemented a medication safety program, targeted at members who take a number of different medications that may have been prescribed by several physicians. We are encouraging these members to have their over-the-counter and prescription medications, as well as vitamins and supplements, reviewed by you, their physician(s).

We feel this program is an important way to educate members about the possible risks of taking multiple medications. Doing so can lead to:

- Increased risk of adverse effects and drug-to-drug interactions
- More difficulty for the patient to take all the medications as prescribed
- Increased risk that the patient may take discontinued or expired medications
- Increased cost to the patient

Informing and Empowering Members

In June, members received a brochure in the mail explaining the purpose of the program and providing them with tips on medication safety. The brochure also included a medication log they can use to record their medications and supplements. Along with the brochure, they also received a small paper bag to use to take their medications and supplements with them on their next office visit.

In order to empower patients to better manage their own health, we've provided them with some questions they should ask you at their next visit:

- What is the purpose of each medication?
- What are the important side effects of each medication?
- How should I take the medication?
- Is this medication safe to take with other medications and/or supplements I am taking?
- Are there generic alternatives available?

As their physician, you may want to consider one or more of the following:

- Changing dose or dose frequency
- Discontinuing or changing a medication
- Using combination therapies to simplify medication regimens

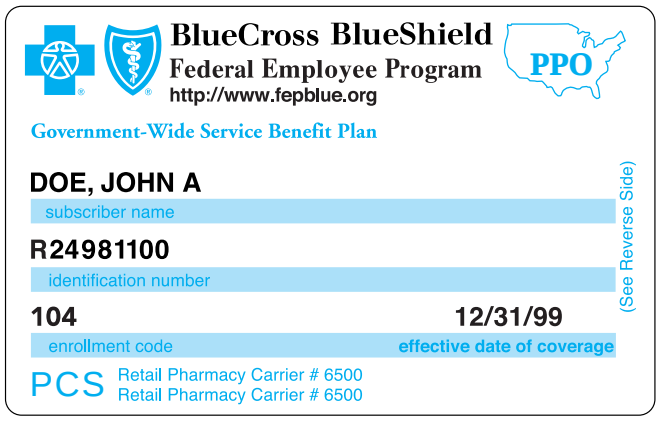
If you have any questions about this program, please contact Denis O'Connell M.D., regional medical director and co-chair of the BCBSNC Pharmacy & Therapeutics Committee at **1-800- 446-8053** or **1-919-765-1368**.

BlueCross BlueShield of North Carolina

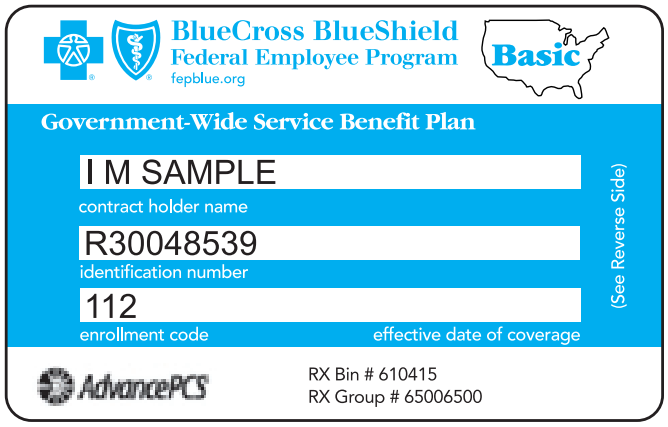
Benefit Updates for the Federal Employee Program

There's a new ID card for FEP members enrolled in the Basic Option plan. There were no changes to the Standard Option ID card. Below are samples of the ID cards for the FEP Service Benefit Plan.

Standard Option



Basic Option



FEP Services Requiring Prior Approval

The Blue Cross and Blue Shield Federal Employee Program requires prior approval for the following services under Standard and Basic Option:

Home hospice care: Contact FEP Customer Service at **1-800-222-4739** before obtaining services. Medical evidence is needed for us to make coverage determination and advise the member of approved hospice care agencies.

Partial hospitalization or intensive outpatient treatment for mental health/substance abuse: Contact FEP Customer Service before obtaining these services. Medical evidence is needed to make coverage determination. We will also consider the necessary duration of either of these services.

Organ/tissue transplants: Contact FEP Customer Service before rendering services. We will request the medical evidence needed to make coverage determination and we will consider whether the facility is approved for the procedure in question.

Clinical trials for certain organ/tissue transplants: Contact our Clinical Trials Information Unit at **1-800-225-2268** for information or to request prior approval before rendering services. Medical evidence will be requested in order to make coverage determination. Use this number only for prior approval of clinical trials for bone marrow and peripheral blood stem cell transplant support procedures or for conditions shown in the Blue Cross and Blue Shield FEP Service Benefit Plan brochure.

Cardiac rehabilitation: Contact FEP Customer Service prior to rendering treatment. We will request the information needed to make any coverage determination.

Prescription drugs: Certain prescription drugs require prior approval. Contact the Retail Pharmacy Program at **1-800-624-5060** to request prior approval, or to obtain an updated list of prescription drugs that require prior approval. The pharmacy program will request the information needed to make coverage determination.

BASIC OPTION ONLY – Outpatient mental health and substance abuse treatment: Contact the Behavioral Health Unit at **1-800-222-4739** before any outpatient professional or facility care treatment begins.

Quick Reference Numbers for the Federal Employee Program

FEP Customer Service **1-800-222-4739**	**Pre-admission Certification** **1-800-672-7897**
FEP Case Management **1-888-234-2415**	**Behavioral Health Hotline** **1-800-222-4739**
Clinical Trails Information Unit **1-800-225-2268**	**Retail Pharmacy Program** **1-800-624-5060**
Blue Health Connection (24-hour nurse line) **1-888-258-3432**	

State Health Plan Claims Filing Reminders

P F A Rx

Medicare Crossover Claims

We continue to receive a high volume of paper claims for State Health Plan members that have Medicare as their primary insurance carrier. Since these claims are submitted with the Medicare Explanation of Benefits (MEOB) attached, they have to be researched to make sure the claims have not already crossed over to us from Medicare and have been previously processed.

If you receive a MEOB with reason code MA18—the claim information is being forwarded to the patient's supplemental insurer—please do not file a paper claim with the State Health Plan. Medicare will automatically forward the claim to us.

Secondary Reimbursement Filing Guidelines

When a State Health Plan member has a commercial carrier that is primary to the State Health Plan, it is imperative to submit the commercial carrier's Explanation of Benefits (EOB) along with the HCFA 1500. Our liability as the secondary carrier cannot be determined without the EOB, and the claim will be held for payment.

Prior Authorization for Durable Medical Equipment

Effective July 1, 2002, the State Health Plan and NC Health Choice will no longer require prior approval for the rental, purchase or repair of covered standard durable medical equipment that is medically necessary and costs less than $1,000 per unit or item. Reimbursement will be based upon the usual, customary and reasonable allowance for the item or service in question.

Impacted Ear Wax Removal

The State Health Plan does not allow benefits for the removal of impacted ear wax (CPT code 69210). Impacted ear wax is considered to be an integral part of medical care and related surgery and is not paid separately.

Specimen Handling

The State Health Plan does not provide benefits for specimen handling (CPT code 99000) when the same provider bills an in-office laboratory procedure for the same date of service. The handling fee is included in the allowance for the laboratory test.

Mailing Addresses

PLEASE NOTE: Claims and correspondence for the State Health Plan are to be sent to different P.O. boxes than those used by Blue Cross and Blue Shield of North Carolina for its lines of business. Delays will result if claims or inquiries are sent to the incorrect address.

State Health Plan claims (other than prescription) should be mailed to:

Claims Processing Contractor
PO Box 30025
Durham, NC 27702

State Health Plan correspondence should be mailed to:

State Customer Services
PO Box 30111
Durham, NC 27702

BCBSNC Offers Hearing Aid Discounts

P A

We began offering Audio Blue℠, a discount program for BCBSNC members* needing hearing aids, as of April 1, 2002. To provide the discount program to our members, we have partnered with members of the North Carolina Audiology Resource Enterprise (NCARE). With Audio Blue, members receive savings of 25 percent off hearing aid devices, fittings, follow-up visits, one-year warranties for service loss or damage, free hearing aid cleanings and checks, and a one-year supply of batteries. The discount does not cover diagnostic audilogical testing. With the Audio Blue discount, members can save from $200 to $800 on a single hearing aid.

To receive the discount, members simply present their ID card to a participating provider at one of many locations throughout North Carolina. Participating audiologists are listed online at ***bcbsnc.com***, or members can call ***1-877-979-8000*** to find out who's participating in their area.

**The State Health Plan and the Federal Employee Program do not offer the Audio Blue discount to their members at this time.*

Prior Approval Procedures for the State Health Plan

State Health Plan members must obtain prior approval for certain services, procedures and items before services are rendered. If prior approval is required, but not obtained, the member will be responsible for the entire cost.

Medical records and a letter from you explaining the need for the services requiring prior approval should be sent to:

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

FAX: 1-919-765-4890
Phone: 1-800-422-1582

Although the member may receive prior approval, it may not guarantee that benefits will be paid. For example, a patient who receives prior approval to purchase a wheelchair, but leaves employment before making the purchase, will not be eligible to receive State Health Plan payment for the item because he or she is no longer enrolled in the Plan.

State Health Plan Services Requiring Prior Approval

The following is a list of some of the services that require prior approval. Please refer to the *Summary Plan Description* for a complete listing.

- Durable medical equipment (all rental and purchases over $500)
- Licensed land ambulance over 50 miles
- Air ambulance
- Any service provided in the home (including home care aides, physical or occupational therapies)
- Speech therapy (except inpatient hospital therapy)
- Private duty nursing
- Skilled nursing facility care
- Hospice care
- Subcutaneous injection
- Temporomandibular joint (TMJ) dysfunction appliance/splint therapy (limited to accidental injuries)
- Botulinum toxin (Botox) injections
- Cochlear implants
- Gastric surgery (for morbid obesity)
- Nasal structure revision
- Oral and orthognathic surgery
- Penile prosthesis
- Reduction mammoplasty
- Transplants (must be on list of covered transplants)
- Varicose vein surgery
- Refer to the *Summary Plan Description* for a complete listing of other surgical procedures requiring prior approval.

Time-Saving Updates and Reminders

Modifiers Are Key

We want to remind you that when modifiers are omitted or incorrectly used, the result can be a denial of the claim or a delay in payment. Our claims system will deny invalid service codes and modifier combinations, so it's extremely important that your claim is completed correctly.

You can find out how to correctly use modifiers and technical components by referring to the *National Physician Fee Schedule Relative Value* file that is published by the Center of Medicare and Medicaid Services. The information is also online at ***www.hcfa.gov***.

Lab Billing

Do not bill BCBSNC for lab services that have been referred to a BCBSNC-participating independent lab for processing. The lab will bill us directly for these services. We will be reviewing claims data in upcoming months to identify duplicate lab services billed for the same member and the same date of service. This is considered double billing, which may result in refund requests or recoupment activity.

Blue Link Now Online

For your convenience and easy reference, *Blue Link* is now available online at ***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!

Transplant Process Changes

Both you and your BCBSNC patients will benefit from the recent enhancements we have made to the way we handle transplant cases. For providers, we have simplified the prior approval process, standardized the required clinical information, and completely automated the claims processing component. For qualifying members, we are now providing them with a credit card to help with travel and lodging expenses and access to 24-hour assistance for travel arrangements. As soon as a BCBSNC patient is identified as a transplant candidate, please call us at ***1-800-672-7897***.

Claims Filing Tips

We would like to suggest that you take a moment and review our claims adjudication policy. The policy, as set forth in Section 8 of the *Physician Office Guide*, allows for claims editing in certain situations. Beginning in the third quarter of this year, our claims adjudication process will more systematically apply edits in the following situations:

Duplicate Submissions: Applied if more than one claim is submitted for the same service or if the same service is included on more than one claim.

Diagnosis to Procedure Mismatch: Applied to procedures that are inconsistent with a given diagnosis.

Upcoded Services: Applied to inappropriate reporting of new patient evaluation and management services.

Precertification for Inpatient Hospital Services

It is your responsibility to obtain certification for inpatient hospital services on behalf of your BCBSNC patients. Failure to obtain the appropriate certification will result in denial of the claim or a reduction in benefits. Denied or reduced amounts cannot be billed to the HMO, POS, or PPO member. Emergency room charges associated with inpatient admissions will continue to process according to Prudent Layperson criteria.

Requests for Duplicate Notification of Payment Forms

We ask that you keep your Notification of Payment (NOP) forms on file for future reference. The NOPs are system-generated and are not easily reproduced. If you use Blue ***e***, you can review claims payments online at your convenience and use that electronic record as a reference point.

Name Search Function on Blue *e*

Remember to verify the BCBSNC patient's date of birth and address before using the Blue ***e*** name search function. Doing so will help ensure that you retrieve the correct patient information. If you need assistance, just call the Provider Blue Line at ***1-800-214-4844***.

BlueCross BlueShield of North Carolina

BlueLINK

Editor: Susan Burkhart
Corporate Communications
Durham, NC 27702-2291

Address Correction Requested

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Visit us online at bcbsnc.com

BCBSNC Welcomes Food Lion

Employees of Food Lion Stores became part of the Blue Cross and Blue Shield family effective 01/01/2002. Members will carry Blue Cross and Blue Shield ID cards with the alpha prefix **FLN**.

Please include the complete alpha prefix (FLN) and the member identification number when sending claims to the local Blue Cross and Blue Shield Plan servicing your area. Claims submitted without the correct alpha prefix will be returned to you for corrections and resubmission.

Important Notice

Effective January 1, 2002, many of the Goodyear Tire and Rubber employees and their covered dependents were issued new ID cards. All claims with DOS on or after January 1, 2002 should be submitted with the new prefix of **"GYR"**. To avoid delays and possible denial of claims, it is critical that you file all claims with the prefix **"GYR"** as shown on the sample ID Card below.