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**BlueCross BlueShield of North Carolina**

[bcbsnc.com](http://bcbsnc.com)



## Have You Discovered the Benefits of Using RealMed?



RealMed is an online real-time claims transaction and resolution portal that connects you to health care payers via the Internet. Blue Cross and Blue Shield of North Carolina (BCBSNC) and RealMed Corporation launched the service to contracting providers in 2001.

The technology allows HCFA-1500 medical claims to be submitted to BCBSNC and resolved electronically at or shortly after the time a patient receives care in your office. As a result, RealMed can reduce your administrative expenses and provide you with expedited claims service for BCBSNC patients. It also offers enhanced eligibility verification along with the streamlined claims submission process.



### Benefits of RealMed

RealMed goes beyond what standard clearinghouses can provide you. Here are just some of the benefits:

- Access to **better eligibility and benefit information**, which will result in cleaner claims with higher acceptance rates.
- Delivers **real-time adjudication** for BCBSNC claims over the Internet and provides you with a full Explanation of Benefits at the point-of-service or when the claim is fully resolved.
- Provides **interactive edits** when a claim has been rejected or pended, so you'll know right away what information is missing or is needed in order to correctly process the claim.
- Provides eligibility and claims submission capabilities for over 800 commercial payers in the U.S. through a flexible **EDI interface**.
- Streamlines your operations by providing a **centralized transaction portal** on the Web and eliminates re-keying for claim entry.
- Ensures **patient privacy** through state-of-the-art data encryption and multiple levels of security.
- Aids practice administrators through **detailed reporting** and analysis information.

# Benefits of Using RealMed (continued)

## RealMed and EDI Submission of Claims

Interactive adjudication of claims and EDI submission can be used simultaneously through the transfer of a single batch file to RealMed as often as you wish. For those EDI claims that do not pass “clearinghouse edits,” you can view and adjust them via RealMed’s user interface or resubmit them to the clearinghouse for transmission to and processing by the payer. For those EDI claims that cannot be electronically transmitted because the payer does not accept EDI transmission, RealMed provides a drop-to-paper print service for a small transaction fee.

## Eligibility Services Available

RealMed offers two levels of eligibility services—enhanced and basic. Each option provides you with immediate access to member eligibility and benefits information. Depending on the nature of the relationship between RealMed and specific payers, this information may include effective and termination dates, benefit limitations, copayments, and plan policies. The difference is that when enhanced eligibility is used for BCBSNC patients, an eligibility inquiry hits directly against our eligibility and coverage information files here at BCBSNC. When you use the basic eligibility for noninteractive payer service, the query is sent through RealMed connections with third party clearinghouses.

The eligibility service allows you to set up a routine schedule for batch submission (or individual queries too) for all patient appointments three to five days ahead of the actual appointment date. Once the payer confirms eligibility, you can view an interactive list on RealMed’s Web site, where you can sort, search, highlight results and even fix and resubmit eligibility failures.

## Want to Know More About RealMed?

The set-up requirements and pricing for RealMed have been significantly changed to favor you, the provider. For more information about how your practice can benefit from using RealMed, contact your EDI Services field consultant, or visit the RealMed Web site at [realmed.com](http://realmed.com).



# A Notice Regarding PARTNERS Members



Blue Cross and Blue Shield of North Carolina (BCBSNC) would like to assist PARTNERS members in their transition to BCBSNC coverage. We understand the concern for quality health care during this period, and we would like to make this a smooth transition for everyone involved. Here are some helpful tips to assist transitioning members during this time.

## Continuity of Care for Medical Services

In rare cases, PARTNERS members will not find their provider included within BCBSNC’s network of participating providers. To assist in this transition, we are offering continuity of care to qualifying members, which will enable them to continue to see a non-participating provider for a certain period of time. For a member to be eligible for continuity of care, treatment must be ongoing and one of the following conditions must apply.

- 1 Member has an acute illness**—a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
- 2 Member has a chronic illness or condition**—a disease or condition that is life-threatening, degenerative or disabling and requires medical care or treatment over a prolonged period of time.
- 3 Member is terminally ill**—a medical prognosis that the individual’s life expectancy is six months or less.
- 4 Member is in second or third trimester of pregnancy or completing postpartum care.**

Please note that BCBSNC must authorize services provided by nonparticipating providers in advance in order for them to receive in-network benefits for care under the continuity of care provisions. PARTNERS members will be asked to confirm whether or not their doctor is currently in the BCBSNC network.

Patients can contact BCBSNC’s Customer Service Department at **1-877-258-3334** to obtain a continuity of care request form. Authorization for continuity of care must be requested within 45 days after the effective date of coverage with BCBSNC.



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# Credentialing Application Now Available Online



Are you interested in becoming a participating provider in Blue Cross and Blue Shield of North Carolina's (BCBSNC's) managed care networks? If so, it's as easy as going online to our Web site at [bcbsnc.com](http://bcbsnc.com) and clicking on the "Provider" portal.

Now available to you online is the "Uniform Application to Participate as a Health Care Practitioner" form and all the information you'll need to apply for credentialing in our HMO/POS and PPO networks. Simply go to the Provider portal and look for the "Resources" section and select the "Apply for Credentialing" option. This will allow you to access the application form and other applicable forms necessary for your credentialing. You can print out the documents or save them as a PDF file directly to your personal computer. Just complete the required information, attach all appropriate forms, and mail or fax them directly to us at:

## Credentialing Department

Blue Cross and Blue Shield of North Carolina

P. O. Box 2291

Durham, NC 27702

FAX NUMBER: 919-765-7016

Please contact your local BCBSNC Network Management field office for contract or provider number information.

## Disposable Contact Lens Discount



We understand that there has been some confusion as to the definition of "disposable contacts" and how it relates to our vision care discount. With your help, we have been able to define disposable contacts as "any multi-packaged lens designed to be replaced at an interval of six months or less."

Vision care providers who participate in all BCBSNC product lines—HMO, POS, PPO, CMM—and who own optical dispensaries should be giving BCBSNC patients a 30 percent discount on prescription eyewear, 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. Please note that ID cards do not reflect the discount information, as the discounts are not covered benefits.

Please contact your local BCBSNC Network Management field office if you have any questions.



## How to Handle Claims for BCBS HMO Members Affiliated with other BCBS Plans



You may see a growing number of Blue Cross and Blue Shield (BCBS) HMO members affiliated with other BCBS Plans seeking care at your office or facility. You should handle claims for these members the same way as you do BCBSNC's members by submitting them to BCBSNC through the BlueCard® Program.

You can identify BCBS HMO members from other Blue Plans by the three-character alpha prefix preceding the member's identification number on their ID card. You may also see this "empty suitcase" identifier, which indicates that the claim should be filed through the BlueCard Program.



**Here's how to handle claims for BCBS HMO members affiliated with other BCBS Plans:**

- With the member's ID card in hand, call BlueCard Eligibility at **1-800-676-BLUE (2583)**.
- When prompted, provide the first three characters of the member's ID number.
- Once the member receives care, please do not ask for full payment up front other than out-of-pocket expenses such as deductible, copayment, coinsurance, and noncovered services.
- Submit the member's claim with the member's complete identification number—including the alpha prefix—to BCBSNC. We will send you an Explanation of Payment or payment advice.

## Blue Card HMO Claims (continued)

Please note that you are not expected to administer managed care for the member nor is a referral necessary. Any referrals you receive from the member are for information purposes only.

If you have any further questions about BCBS HMO members affiliated with other Blue Plans and/or the BlueCard program, give us a call at **1-800-487-5522**.

## Tips from BlueCard Host Customer Service



If you have called BlueCard Host Customer Service recently, you may have experienced a bit of a wait before your call was answered. This is because our representatives are spending more time on the phone with our providers in order to resolve your inter-plan questions during the course of one call. It's our version of "one stop shopping."

BCBSNC's BlueCard Department is working on solutions to reduce your wait time. We want to thank you for your patience. In the future, if you have multiple inquiries, our representative may ask if you want to fax those inquiries in to us with a guaranteed response time. Customer Service personnel will be working directly with claim specialists in order to resolve your inquiries quickly.

The BlueCard Host Customer Service team would also like to share a few tips with you to help you better utilize the BlueCard program and save valuable time:

- You can easily check claim status yourself by using Blue e<sup>SM</sup>.
- Please allow 21 days for a claim to process before calling to check its status.
- You can check member eligibility by calling BlueCard Eligibility at **1-800-676-BLUE (2583)**.
- There are out-of-state members who do not participate in the BlueCard program. If you have been asked to send the claim directly to the out-of-state BCBS Plan or have received a Notification of Payment from another state, please call that BCBS Plan with your questions.
- Please make every effort to stay available when you call us. Placing us on hold results in a delay of service to the next provider.

## Radiology Services Added to Prior Plan Approval List



In August, BCBSNC sent a letter to physicians informing you that select radiology services were being added to BCBSNC's Prior Plan Approval (PPA) requirements as of December 2, 2002. The following select outpatient, non-emergency radiology services will now require authorization:

- magnetic resonance imaging (MRI)
- magnetic resonance angiography (MRA)
- computerized tomography (CT) scans
- positron emission tomography (PET) scans
- nuclear cardiology studies

These additions to the PPA list only apply to Blue Care<sup>®</sup>, Blue Choice<sup>®</sup>, and Blue Options<sup>SM</sup>.

### Targeted Program

The program is targeted and does not require that all physicians obtain authorization through the PPA process. Physicians who are initially exempt from obtaining PPA will only be required to provide notification of the radiology services prior to the services being rendered.

While prior notifications are treated as an administrative authorization and do not entail a review of the service request, they are necessary to prevent claims denial for no authorization. *All physicians referring a member for any of the services noted above must request PPA or provide notification prior to these services being rendered. Physicians providing the above-noted radiology services should verify that the referring physician has obtained authorization prior to rendering services. If the service has not been authorized, the claim will deny for no authorization.*

We will provide you with more detailed information regarding this program in November.



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# BCBSNC Participating Labs



Participating network physicians have contractually agreed that when the need arises for a BCBSNC patient to receive other professional services—such as reference laboratory services—they will refer our members to other participating network providers. The following laboratories are participating in all BCBSNC products:

- BioClinical Concepts
- Carolina Medical Lab
- Clinical Laboratory Services
- Dianon Systems
- Fullerton Genetics Center
- GeneCare Medical Genetics Center
- Genzyme Genetics
- Harris Histology Relief Service
- Laboratory Corporation of America
- Meridian Laboratory Corporation
- Physicians Laboratory Services
- Quest Diagnostics Clinical Laboratories
- Rex Laboratory Outreach Services
- Select Diagnostics
- Skin Pathology Associates
- Spectrum Laboratory Network
- St. Joseph's Reference Laboratory
- Triad Clinical Laboratory
- UNC Hospitals McLendon Clinical Laboratories
- US Labs
- Wescott Laboratories
- Wilkesboro Clinical Lab



If you currently use the services of a nonparticipating reference laboratory, please encourage them to contact BCBSNC for more information about becoming a contracting provider in our networks. Reference labs that would like to participate in our networks can request an application by contacting the Hospital and Ancillary Network Department at [919-765-2430](tel:919-765-2430).

[bcbsnc.com](http://bcbsnc.com)



## Attention DME Providers: Notice of Code Changes due to HIPAA



The Health Insurance Portability and Accountability Act (HIPAA) is imposing impacts on the health care industry that include the use of universal codes for services or durable medical equipment. For health plans, providers, and health care clearinghouses, the critical portions of the act are the “Administrative Simplification” provisions that spell out the code changes.

### Changes Effective October 1, 2002

One of these provisions requires that all health care providers use standard codes and identifiers (ICD9, CPT, and HCPCS) when submitting claims to payers. As a result, local Blue Cross and Blue Shield of North Carolina (BCBSNC) homegrown codes will be eliminated as of October 1, 2002. As of this date, the following BCBSNC maintenance and repair codes will be deleted from your Ancillary Services Provider Agreement:

- **DM801**—services by a licensed respiratory therapist for E0601, K0532
- **DM802**—services by a respiratory therapist for E0601, K0532
- **DM803**—services by a respiratory therapist for E0450, E0457, E0460, E0500
- **DM804**—services by a licensed respiratory therapist for E1390, E0439
- **DM805**—services by a respiratory therapist for E1390, E0439
- **DM504**—pulse oximeter
- **ALL OTHER BCBSNC local, homegrown codes that you may be currently using will also be eliminated as of October 1, 2002.**

As homegrown codes such as these are no longer acceptable, you must use standard codes and identifiers. If a standard code is not available for the service rendered, then the appropriate miscellaneous/unlisted code may be used. As always, when a miscellaneous code is used, you must submit an itemized invoice with the claim that fully describes the service in question.

### Official Notice of Change

Please note that as federal law—prompted by HIPAA—requires a contract change, this serves as your notice of change to your current Ancillary Services Provider Agreement with BCBSNC (pursuant to section 9.2). Thank you for your help in ensuring that both your office and BCBSNC are in compliance with HIPAA.

# Provider Blue Line<sup>SM</sup> At Your Service



Did you know that you can call the Provider Blue Line for automated information regarding benefits, claims, and eligibility for all Blue Cross and Blue Shield of North Carolina members (with the exception of the Federal Employee Program)? It's true, and we've recently learned that many providers were not aware that they could use the Provider Blue Line to obtain State Health Plan and NC Health Choice information.

When you call the Provider Blue Line at **1-800-214-4844**, you will be prompted to input the patient's BCBSNC, State, or NC Health Choice ID number, their date of birth, and the date of service in question. Once you enter this information, you will be automatically connected to the appropriate menu and customer service department.

## State Health Plan and Modifiers 57 and 25



The State Health Plan recognizes modifier 57 only on limited observation and inpatient evaluate and management (E&M) codes. Please note that the State Health Plan does not recognize modifier 57 if it is filed with any outpatient, emergency room, or office visit E&M codes.

Here are the codes with which the State Health Plan will accept modifier 57:

99218, 99219, 99220	Observation
99221 to 99223	Initial Hospital Care
99231 to 99233	Subsequent Hospital Care
99251 to 99255	Initial Inpatient Consultations
99261 to 99263	Follow-up Inpatient Consultations
99271 to 99275	Confirmatory Consultations

The State Health Plan does recognize modifier 25 for outpatient, emergency room, or office visit E&M codes for new patients only.

Here are the codes with which the State Health Plan will accept modifier 25:

99241 to 99263	Consultation
99201 to 99215	Office/Outpatient Visit
99281 to 99285	Emergency Room Visit
99341 to 99350	Home Care
99291, 99292	Critical Care

## State Health Approval Requirements for DME

Effective July 1, 2002, prior approval is no longer required for durable medical equipment (DME) when the reimbursement is less than \$1,000 per unit or covered item. This includes:

- DME rentals when the purchase price is less than \$1,000.
- DME purchases or repairs when the reimbursement is less than \$1,000 (includes prosthetics, orthopedic, and orthotic appliances).
- DME when Medicare is primary and the DME is covered by Medicare—regardless of cost.



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## State Health Plan: Ambulance Service

To ensure that ambulance claims are paid correctly, it is imperative that we receive all of the necessary codes when the claim is submitted to us for consideration. HCPCS codes, which best describe the services rendered, should be assigned to the claim.

When using codes A0434 and A0999, remember to give a complete description of the services since these codes do not provide detailed information. In addition to the HCPCS codes, please assign ICD-9 codes as appropriate based on the patient's symptoms. Also, remember to give the correct modifiers indicating the location of the service and the destination for the trip.

These requirements will be strongly enforced in order to provide the best service to our State Health Plan members. Submitting the correct and necessary information the first time will prevent claims from being mailed back to you requesting missing information.

# Time Saving Reminders and Updates



## Hot and Cold Packs

Please note that hot and cold packs provided in conjunction with physical medicine services are generally considered integral to other modalities and procedures being rendered. The application of hot and cold packs when used alone is not a covered service.

## Clinic Billing

Please remember that institutional claims for clinic services using revenue codes 510, 519, and 520 are no longer eligible for reimbursement for services rendered after April 30, 2002, for Blue Care, Blue Choice, Blue Options, and Classic Blue® members.

## Emergency Room Services

Charges for an emergency room visit or services that result in an inpatient admission must be billed on a UB-92 along with the charges for the inpatient admission. These charges should not be split out and billed separately. Charges for an ER visit that does not result in an approved admission must be submitted separately for consideration of payment. These services will be subject to existing prudent layperson language and if approved, will be reimbursed according to the current outpatient reimbursement guidelines for your facility.

## Patient Lifts

BCBSNC HMO and POS products require Prior Plan Approval for durable medical equipment that has a rental or purchase price of more than \$1500. Patient lifts–E0630 and E0635–were recently added to the DME Prior Plan Approval list.

## Student Groups Can Now Enroll in Blue Options

We are pleased to announce that Duke, N.C. State, and UNC students are now covered by our Blue Options plan. To verify benefits or eligibility for these students, just call us on the Provider Blue Line at [1-800-214-4844](tel:1-800-214-4844).

## Only National Codes Now Accepted

As of October 1, 2002, we began to only accept active codes from national code set sources such as ICD-9, CPT, and HCPCS, as part of our HIPAA compliance measures. As new codes are released, please convert to them by their effective date in order to prevent claims from being mailed back for recoding or resubmission. Deleted codes will not be accepted for dates of service after the date the code becomes obsolete. Contact your local BCBSNC Network Management representative if you have questions.

## State Appeals and Grievances Address Change

Please note that the mailing address for the submission of appeals or grievances to the North Carolina State Health Plan and NC Health Choice has changed to:

State Review  
Appeals and Grievances  
P.O. Box 3869  
Durham, NC 27702-3869

## Merck-Medco Changes Name to Medco Health

Merck-Medco Managed Care, L.L.C., which is BCBSNC's pharmacy benefits manager, has changed its name to Medco Health Solutions, Inc. (Medco Health). This change also impacts Medco Health's two subsidiaries–Paid Prescriptions, L.L.C., which is now Medco Health Prescriptions Solutions, L.L.C. and Merck-Medco Home Delivery Pharmacy Service, which is now Medco Health Home Delivery Pharmacy Service. All addresses will remain the same.

## Assistant Surgeons

Please remember to bill separately for services performed by an assistant surgeon. This includes services filed with modifiers 80, 81, 82, and AS. Claims billed separately from the primary surgeon's charges and with the correct modifiers will be processed in a timelier manner.



# EDI Services Web Page Now Available



You can now access information about EDI Services online at [bcbsnc.com/providers/edi](http://bcbsnc.com/providers/edi). EDI Services develops and supports the electronic transmission of claims, inquiries, and remittances with contracting health care providers or their supporting billing services, claim clearinghouses, or vendors.

## EDI Services include:

- Implementation of HIPAA-compliant electronic transactions.
- Blue *e* development, maintenance, and customer support.
- Customer support for electronic connectivity.

As you move toward HIPAA compliance over the coming year, the EDI Web page will provide you with important information relevant to the transition. This will include transaction-specific companion guides and auxiliary documents to help you and your office business managers plan your move from HCFA and UB92 formats to ANSI ASC X12N format.

## The EDI Services Web site offers:

- BCBSNC's schedule for the implementation of HIPAA electronic transactions.
- BCBSNC's Companion Guides to HIPAA electronic transactions.
- Trading Partner Agreement—required for transmitting electronic transactions with BCBSNC.
- Electronic Connectivity Request (ECR) forms for all transactions.
- Sample documents relevant for the transition to HIPAA compliant formats:
  - Claims Audit Report
  - ANSI ASC X12N 997 transaction
  - ANSI ASC X12N TA1 transaction
- Blue *e* contract and technical template for new customers.
- Forms for current Blue *e* customers to add new users or providers.
- Contact information for EDI Services Customer Support and EDI field representatives.



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# BCBSNC's Clinical Formulary Helps You and Our Members



Hopefully, you received the most updated version of our clinical formulary, which we mailed to all network providers in July. The formulary provides information regarding two-tier and three-tier benefit plans. It's designed to assist you in maintaining quality of care while minimizing your patients' out-of-pocket expense for prescription drugs.

By prescribing generic medications—when clinically appropriate—you will help limit the cost of drugs for your patients. For members enrolled in three-tier benefit plans, you can also help limit their drug costs by prescribing preferred brands, which are Tier 2 drugs. For Personal Care Plan<sup>SM1</sup> and Blue Care members, certain drugs may require prior approval or be subject to quantity limitations. These are duly noted in the formulary. Additional information, including the most current version of BCBSNC's formulary, also can be found on our Web site at [bcbsnc.com](http://bcbsnc.com).



## Rx Formulary Updates



Please note that the following prescription drugs have been moved to different tiers:

<b>Moved to Tier 2 on March 22, 2002:</b>
Viread
Tracleer
Ortho Evra
Entocort EC
Clarinox
Micardis/Micardis HCTZ
Lumigan
<b>Moved to Tier 3 on March 22, 2002:</b>
Vantin
<b>Moved to Tier 2 on July 10, 2002:</b>
Rebif

# Practice Tips:

## Careful Antibiotic Use



It will soon be the start of cold and flu season, and we all know that means patients will be coming in looking for relief. It's important to educate patients that antibiotics are not the magic cure for all that ails them. The following practice tips have been provided by the Centers for Disease Control and Prevention (CDC) as part of their ongoing campaign to fight antibiotic resistance. We hope you will find them helpful.

### What to do when parents ask for antibiotics to treat viral infections:

- **Explain that unnecessary antibiotics can be harmful.**  
Tell parents that based on the latest evidence, unnecessary antibiotics CAN be harmful as they promote resistant organisms in their child and the community.
- **Share the facts.**  
Explain that antibiotics can cure bacterial infections, but they cannot cure viral infections. Also, let them know that treating viral infections with antibiotics does not in turn prevent bacterial infections.
- **Build cooperation and trust.**  
Convey a sense of partnership and don't dismiss the illness as "only a viral infection."
- **Encourage active management of the illness.**  
Explicitly plan treatment of symptoms with parents. Describe the expected normal time course of the illness, and tell parents to come back if the symptoms persist or worsen.
- **Be confident with the recommendations to use alternative treatments.**
  - Prescribe analgesics and decongestants, if appropriate.
  - Emphasize the importance of adequate nutrition and hydration.
  - Consider providing "care packages" with non-antibiotic therapies.

You can access these tips and many other resources at [cdc.gov/antibioticresistance](http://cdc.gov/antibioticresistance). You may order many of these materials free-of-charge for your office.



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# Nutrition and Fitness Discounts with Get Fit Blue<sup>SM</sup>



Effective October 1, Blue Cross and Blue Shield of North Carolina (BCBSNC) began offering Get Fit Blue—a nutrition and fitness resource and discount program for our members. With Get Fit Blue, members\* will receive significant savings on weight-management programs, products and services.

The Centers for Disease Control and Prevention (CDC) estimates that over 21 percent of North Carolina adults are obese. Studies show that obese people are at greater risk of having diabetes, heart disease, high blood pressure, gallbladder disease, arthritis, breathing problems, and some forms of cancer.

It is estimated that Americans spend \$33 billion dollars per year on weight-reduction products and services, including diet foods, products and programs. By offering this discount program, members can save up to 40 percent on hospital weight-management programs. BCBSNC members can also save on weight-loss tracking equipment such as heart rate monitors, body fat analyzers, scales, electric pulse massagers, and blood pressure monitors.

To receive the weight-management program discount, members simply present their BCBSNC ID cards to a participating hospital at one of many locations throughout North Carolina. Participating hospitals are listed online at our Web site [bcbsnc.com](http://bcbsnc.com).



[bcbsnc.com](http://bcbsnc.com)



\*At this time, the State Health Plan does not offer the Get Fit Blue discount program to its members.

# Could Your Patients Benefit From our Health Management Programs?



Blue Cross and Blue Shield of North Carolina offers free, confidential health management programs designed to complement your plan of care. We have programs for eligible members with asthma, diabetes, migraine headaches, rheumatoid arthritis, lupus, MS, and other complex, chronic conditions. We also offer a prenatal program for expectant mothers, both high and low risk.

Participating members receive the following:

- Comprehensive reference books and other educational materials.
- Self-management tools, such as peak-flow meters, spacers, and blood glucose meters.
- The opportunity to work with a BCBSNC registered nurse for personalized education and support.

To learn more about our health management programs or to refer a patient, contact us at [1-800-218-5295](tel:1-800-218-5295) or visit our Web site at [bcbsnc.com](http://bcbsnc.com).

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## Diabetes Collaborative Needs Your Support



The North Carolina Diabetes Prevention and Control Program is proposing to initiate a state-based diabetes collaborative to improve the quality of diabetes care in the primary care setting. This is a multi-component, quality improvement, disease management initiative based on the chronic care model developed by the Institute for Health Care Improvement and adopted by the Bureau of Primary Health Care for all federally-qualified community health centers. The Collaborative is a gathering of a variety of health care teams committing to a 12-month period of rapid change in the delivery of care to their diabetes patients, with the goal to make sustainable system changes and improvements in diabetes care.

The Program is currently seeking grant funding from the Robert Wood Johnson Foundation's Improving Chronic Illness Care Program. During this process, they have enlisted the support of a variety of partners, including the NC Primary Health Care Association, the Division of Medical Assistance, the Medical Review of North Carolina, and the NC Diabetes Advisory Council. They have also garnered the commitment of a variety of primary care sites, including community health centers, rural health centers, and hospital-based clinics. If your practice site would be interested in participating in the Diabetes Collaborative, please contact the North Carolina Diabetes Prevention and Control Program at [919-715-3131](tel:919-715-3131).

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## Routine Depression Screening Recommended for Adults



This spring, the U.S. Preventive Services Task Force (USPSTF) recommended that primary care physicians routinely screen adults for depression.

Between 5 percent and 9 percent of adults suffer from major depression. Two related conditions—dysthymia and minor depression—are equally as common, according to the USPSTF. Up to half of major depression cases go undetected, leading to higher medical utilization and \$17 billion in lost workdays nationwide each year.

### Screening is Vital

Based on a review of randomized trials, the USPSTF found good evidence that screening improves the accurate identification of depressed primary care patients and that treating adults in this setting reduces clinical morbidity. No screening tool proved more effective than others, and indeed, investigators found that two simple questions may be as effective as longer screening tools. These are:

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

Patients who answer “yes” to either question should undergo full diagnostic interviews using standard criteria (such as the DSM-IV) to determine whether a specific depressive disorder is present, to gauge the severity of depression, and to address any co-morbid mental health conditions. It is estimated that between 24 percent and 40 percent of patients who screen positive will have major depression. Others may have dysthymia or minor depression.

# Depression Screening for Adults (continued)

## Treatment Recommendations

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

Blue Cross and Blue Shield of North Carolina would like to join the USPSTF in encouraging front-line physicians to screen adults. Individuals at increased risk for depression include women, patients with a family history of depression, the unemployed, and those who suffer from a chronic disease.

## Free Diagnostic Tools Available

We have tools available to assist you in screening your adult patients for depression. Please write to us at [quality@bcbsnc.com](mailto:quality@bcbsnc.com) to receive a complimentary set of Zung self-rating depression scales, physician depression screening checklists, patient education sheets on antidepressant medication adherence, and major depression diagnostic criteria charts. Let's work together to help patients overcome the debilitating effects of depression.

## Assessing and Managing the Suicidal Patient: Keeping the Patient Safe

### When should an assessment be conducted?

A suicide assessment should be conducted:

- on any patient with mental illness or substance abuse diagnosis at intake
- at each subsequent session

Each assessment must be documented and include:

- risk factors, and
- interventions

### What are the elements for assessing suicide?

There are two elements to assess:

- Elicitation of **suicidal ideation**
- Identification & quantification of **risk factors**

### How do I assess ideation?

Suicide **assessment tools** can be helpful; however, at minimum, you need to:

- Ask **general questions** regarding degree of thoughts about self-harm.
- Determine **frequency and circumstances**.
- Characterize thoughts as **passive or active**.
- Determine if there is current **intent**, or a **plan**.
- Ask for plan **details** including **rehearsals**.
- Determine if there's a **history** of thoughts, wishes, impulses, acts.
- Assess **means** available and or **access to means**.
- Assess **patient attitude**.
- Assess **barriers** to suicide.
- Determine if **anything is different** this time or expected in the near future.
- Determine if patient **shared ideation** with anyone.
- Determine if anyone **would be helpful** in managing the ideation.

### How do I quantify risk factors?

Patients are at greater risk for suicide if:

- they have had psychiatric hospitalization within the past year.
- depression is present.
- they've had a recent or impending loss.
- substance abuse is present.
- they have a history of impulsive or dangerous behavior.
- suicidal behavior or attempts have occurred previously.
- they have access to guns.
- there's a family history of suicide.
- they are socially isolated.
- they have a chronic, terminal or painful medical disorder.
- they have advanced age.
- they are newly diagnosed with serious medical problems.
- they are male over age 65.

### What are the top high risk diagnoses?

- 1 Depression
- 2 Bipolar disorder
- 3 Alcohol and substance abuse
- 4 Schizophrenia
- 5 Borderline personality disorder

### So how do I manage the suicidal patient?

- Conduct thorough assessment
- Mitigate, eliminate risk factors
- Strengthen barriers
- Treat underlying disorder

*When risk is severe and imminent, a medical emergency can exist requiring immediate containment and intensive medical treatment, usually in a hospital setting.*

If risk is **not** imminent:

- Develop outpatient safety plans, including a **family** plan.
- Establish therapeutic alliance, and
- Use appropriate medications.

# Do You Have the Right to Appeal?



Have you ever been denied payment for a claim, and you did not agree with the decision? According to our Appeals Department, there are three common reasons why payment or coverage for services may be denied:

- The service may not be medically necessary according to BCBSNC guidelines.
- The service is not covered under the patient's health plan.
- You are not a participating provider in the member's health plan network.

To determine whether or not a service is covered by a patient's health plan, contact the Customer Service Department number listed on the patient's ID card. The Customer Service representative can help you review the benefits in question. To determine whether a service or procedure is considered medically necessary by BCBSNC, visit our Web site at [bcbsnc.com](http://bcbsnc.com), where you can review our Corporate Medical Policy.

If you still disagree with the denial of payment or service, you can request a provider courtesy review or have the patient appeal the decision. You can begin the courtesy review process while on the phone with the Customer Service representative by requesting that we reconsider the denial of payment or service. If you are dissatisfied with the outcome of this informal review, there are two levels in the formal appeals process, which may be pursued directly by either the member or you on their behalf with the member's written authorization. The member may contact our Appeals Department to begin the formal process or to obtain an authorization form.

## Level One Review

At this level, the member or authorized representative can appeal the decision by submitting a written request that includes a full explanation of why the member disagrees with the decision and why a review is being requested. Be sure to supply any documentation that supports the member's position. A BCBSNC internal appeals committee will review the information. If the member disagrees with the committee's decision, the member or authorized representative can proceed to the next level of the review process.

## Level Two Review

The member or authorized representative must state in writing why he or she disagrees with the outcome of the Level One appeal. At this level, an external panel will conduct the review. Based on the specific needs of the case, the external panel may include specialty-matched physicians or benefit administrators.

Keep in mind that throughout the entire appeals process, the Appeals Department is available to provide assistance to you or the member. Please remember that all requests for review must be submitted within 180 days of the date of the contested decision. Refer to your *BCBSNC Provider Manual* for more complete details on the appeals process. Some members may have additional rights under Senate Bill 199 and ERISA/Department of Labor rules.



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# How Are Medical Necessity Determinations Made?



Licensed nurses and physicians using established criteria make all medical necessity determinations at BCBSNC. We use two sources—Milliman & Robertson Care Guidelines (M&R) and the BCBSNC Corporate Medical Policy. Nurses use M&R guidelines the majority of the time to authorize coverage for inpatient services and for length of stay extensions. They also use the M&R guidelines for home care and rehabilitation services. BCBSNC Corporate Medical Policy applies more to services on our Prior Plan Approval list. You can obtain a copy of an M&R guideline or a medical policy by calling our Medical Resource Management Department at [1-800-672-7897](tel:1-800-672-7897), ext. 7078. Our Corporate Medical Policy is also available through the BCBSNC Web site at [bcbsnc.com](http://bcbsnc.com).

If a nurse cannot approve a service, a BCBSNC medical director will review the case and may approve or deny coverage based on M&R or BCBSNC Medical Policy, along with clinical judgment. ONLY a medical director can deny coverage for a service based on medical necessity. Practitioners are encouraged to take advantage of the offer of a “peer-to-peer” consultation regarding a case before or after a determination, because a discussion between physicians can usually help clarify a situation and affect the determination. A BCBSNC medical director is always available during regular business hours and can be reached at [1-800-672-7897](tel:1-800-672-7897), ext. 1019.



[bcbsnc.com](http://bcbsnc.com)



## Patient Safety Measures in Place



Did you know that Blue Cross and Blue Shield of North Carolina has initiatives in place to help reduce medical errors? Since physician prescribing and treatment practices have received a great deal of attention recently, BCBSNC closely monitors and tracks patient safety-related events. The following initiatives aim to prevent such medical errors at the member and physician level:

- BCBSNC Quality Management consultants provide training to improve provider knowledge of safe clinical practices during onsite office visits.
- Retrospective and concurrent drug utilization reviews alert prescribing physicians, as well as pharmacists (at the point-of-sale), to potential medication errors and interactions for members.
- The Appropriate Antibiotic Use Program was developed to reduce medication errors and avoid inappropriate use of antibiotics.
- The Medication Safety Program targets members who take a number of different medications that may have been prescribed by several physicians. Members are encouraged to have their over-the-counter and prescription medications, as well as vitamins and supplements, reviewed by their physician.
- Health Line Blue<sup>SM</sup> nurses provide information to members on shared-decision making and safe medical procedures.
- BCBSNC maintains clinical practice guidelines to encourage appropriate diagnosis and treatment of chronic conditions.



Patient safety interventions such as these can ultimately reduce unnecessary medical expenses and keep our members safe and healthy. For more information about patient safety, contact us at [quality@bcbsnc.com](mailto:quality@bcbsnc.com).

# Attention Managed Care Primary Care Physicians: Medical Records Standards



In conjunction with our Physician Advisory Group, and based on NCQA requirements, medical records standards were developed to encourage the quality and appropriateness of physician documentation in office medical records. It is against these standards that medical record reviews are conducted every two years on selected physicians.

*The standards printed in bold italics are considered key elements of a medical record and warrant close attention.*

Standard	Supporting Documentation
1 All pages contain patient identification.	1 Each page in the medical record must contain the patient's name or ID number.
<b>2 <i>Each record contains biographical/personal data.</i></b>	2 Biographical/personal data is noted in the medical record. This includes the patient's address, employer, home and work telephone numbers, date of birth, and marital status. This data should be updated periodically.
3 The provider is identified on each entry.	3 Each entry in the medical record must contain author identification (signature or initials).
4 All entries are dated.	4 Each entry in the medical record must include the date (month/day/year).
5 The record is legible.	5 The medical record must be legible to someone other than the writer.
<b>6 <i>There is a completed problem list.</i></b>	6 The flow sheet includes age appropriate preventive health services. A BLANK PROBLEM LIST OR FLOW SHEET DOES NOT MEET THIS STANDARD.
<b>7 <i>Allergies and adverse reactions to medications are prominently displayed.</i></b>	7 Medication allergies and adverse reactions are PROMINENTLY noted in a CONSISTENT place in each medical record. If significant, allergies to food and/or substances may also be included. Absence of allergies must also be noted. Use NKA (no known allergy) or NKDA (no known drug allergy) to signify this. It is best to date all allergy notations and update the information at least yearly.
<b>8 <i>The record contains an appropriate past medical history.</i></b>	8 Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (age 18 and younger) past medical history relates to prenatal care, birth, operations and childhood illness. The medical history should be updated periodically.
9 Documentation of smoking habits and alcohol use or substance abuse is noted in the record.	9 The medical record should reflect the use of or abstinence from smoking (cigarettes, cigars, pipes, and smokeless tobacco), alcohol (beer, wine, liquor), and substance abuse (prescription, over-the-counter, and street drugs) for all patients age 14 and above who have been seen three or more times. It is best to include the amount, frequency, and type in use notations.
10 The record includes a history and physical exam for presenting complaints.	10 The history and physical documents appropriate subjective and objective information for presenting complaints.

# Medical Records Standards (continued)

Standard	Supporting Documentation
11 Lab and other diagnostic studies are ordered as appropriate.	11 Lab and other diagnostic studies are ordered as appropriate to presenting complaints, current diagnosis, preventive care, and follow-up care for chronic conditions. It is best to note if the patient refuses to have recommended lab or other studies performed.
12 <i>The working diagnoses are consistent with the diagnostic findings.</i>	12 The working diagnosis is consistent with the findings from the physical examination and the diagnostic studies.
13 <i>Plans of action/treatments are consistent with the diagnosis(es).</i>	13 Treatment plans are consistent with the diagnosis.
14 Each encounter includes a date for a return visit or other follow-up plan.	14 Each encounter has a notation in the medical record concerning follow-up care, calls, or return visits. The specific time should be noted in days, weeks, months, or PRN (as needed).
15 Problems from previous visits are addressed.	15 Unresolved problems from previous office visits are addressed in subsequent visits.
16 Appropriate use of consultant services is documented.	16 Documentation in the record supports the appropriateness and necessity of consultant services for the presenting symptoms and/or diagnosis.
17 Continuity and coordination of care between primary and specialty physicians or agency documented.	17 If a consult has been requested and approved, there should be a consultation note in the medical record from the provider (including consulting specialist, SNF, home infusion therapy provider, etc.)
18 Consultant summaries, lab, and imaging study results reflect review by the primary care physician.	18 Consultation, lab, and x-ray reports filed in the medical record are initialed by the primary care physician or some other electronic method is used to signify review. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.
19 <i>Care is demonstrated to be medically appropriate.</i>	19 Medical record documentation verifies that the patient was not placed at inappropriate risk as a result of a diagnostic or therapeutic process.
20 A complete immunization record is included in the chart.	20 Pediatric medical records contain a completed immunization record or a notation that “immunizations are up-to-date.”
21 Appropriate use of preventive services is documented.	21 There is evidence in the medical record that age appropriate preventive screening and services are offered in accordance with the organization’s practice guidelines. (Refer to the Medical Policy section of your <i>BCBSNC Provider Manual</i> .) It is best to note if patient refuses recommended screenings and/or services.
22 Charts are maintained in an organized format.	22 There is a record keeping system in place that ensures all charts are maintained in an organized and uniform manner. All information related to the patient is filed in the appropriate place in the chart.
23 There is an adequate tracking method in place to insure retrievability of every medical record.	23 Each medical record required for patient visit or requested for review should be readily available.

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Visit us online at [bcbsnc.com](http://bcbsnc.com)

## Protecting Your Patients' Health Care Needs



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

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

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



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