BlueLINK SM

News from Blue Cross and Blue Shield of North Carolina

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BlueCross BlueShield of North Carolina

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BCBSNC Leads N.C. in Key Quality Measurements

Blue Cross and Blue Shield of North Carolina (BCBSNC) leads other health plans in North Carolina on a number of customer-oriented quality measures, according to data from the National Committee for Quality Assurance (NCQA). Along with its subsidiary – PARTNERS National Health Plans of North Carolina – BCBSNC received high marks for health management programs, claims processing and overall customer service.

The results for BCBSNC and PARTNERS include the following*:

- The combined BCBSNC and PARTNERS plans held a first-or second place standing in 97.4 percent of the 39 effectiveness-of-care measures in the study. These categories range from immunization rates to disease management and preventive measures for various forms of cancer, cardiovascular health, pre-natal/post-partum care, diabetes, asthma and other conditions.
- BCBSNC and PARTNERS held the top composite scores for customer service with both companies outpacing the South Atlantic regional average of 68.8 percent.
- In 2002, 91.4 percent of BCBSNC's HMO and POS customers responded that the company's paperwork is "not a problem" for them. This marks the third year in a row that this measure of customer satisfaction has improved.
- For the past three years, BCBSNC has shown steadily improving scores in claims processing for its HMO and POS customers. With a composite score of 90.0 percent, BCBSNC holds the number one composite score rating for 2002 of any HMO/POS insurer in North Carolina and stands well above the South Atlantic regional average of 84.3 percent.
- For PPO customers, BCBSNC showed a 7.8 percent increase in overall claims processing from 84.5 percent in 2001 to 91.1 percent in 2002.
- PARTNERS ranked first among all North Carolina health plans for overall customer satisfaction.

(Please see Key Quality Measurements on page 2)

Key Quality Measurements (continued)

The report combines findings from two sources: 1) claims data as reported in HEDIS® (the Health Plan Employer Data and Information Set); and 2) customer survey data from the Consumer Assessment of Health Plans Study (CAHPS) compiled for BCBSNC and submitted to NCQA by the independent research firm, Intelliscan, Inc.

Through continued collaborative efforts, together, we can remain leaders in providing North Carolinians with quality health care. For more information about our Quality Management Improvement Program, please email us at **quality@bcbsnc.com**.

HEDIS® is a registered trademark of the National Committee for Quality Assurance. *The source for data in this article is Quality Compass® 2002 and is used with the permission of the National Committee for Quality Assurance.

Members in Our Asthma and Prenatal Care Programs Show Marked Medical Improvement

Results from two Blue Cross and Blue Shield of North Carolina (BCBSNC) health management programs show that the company's efforts are resulting in medical improvements for key groups of customers. Two BCBSNC programs – Your Asthma Care and Your Baby & You℠ – report high levels of patient satisfaction and positive health outcomes.

One especially noteworthy statistic is that, at 7 percent, the preterm birth rate among mothers in BCBSNC's Your Baby & You program is below the "Healthy People 2010" goal of 7.6 percent. Healthy People 2010 is a set of national health objectives developed by leading federal agencies.

One of the components of BCBSNC's Your Asthma Care program, for example, involves communicating with physicians when patients are not filling prescriptions as quickly as their reported condition seems to warrant. Physicians are then able to follow up with patients and verify if they're taking medication prescribed. Participants in the Your Baby & You program receive comprehensive information about how to have a healthy pregnancy, including information on how to recognize the warning signs of preterm labor.

Other medical improvement results based on BCBSNC data for Your Asthma Care are:

- 12 percent increase in the number of participants appropriately using prescribed asthma medications
- 37 percent improvement in participants' self-reported understanding of how to prevent an asthma attack
- 38 percent improvement in participants' self-reported understanding of how to identify the triggers of an asthma attack
- 54 percent decline in emergency room visits since the program began in 1998
- 58 percent decline in hospital admissions since 1998

Other medical improvement results based on BCBSNC data for Your Baby & You are:

- 21 percent decrease in the preterm birth rate for BCBSNC mothers since the program began in 1998
- 29 percent decrease in the number of days babies spent in the neonatal intensive care unit since 1998

"As a health care company, one of our core commitments is to provide our customers with the information and resources they need to make the best possible health care decisions for themselves," said Dr. Doug Knoop, BCBSNC's senior medical director of Population Health Management. "With programs like Your Asthma Care and Your Baby & You, information can be channeled down to customers so they can learn about medications or procedures they may not know about. We want people accessing medical care. We want them engaged in improving their health, and we want them to have the health information that helps them do that."

BlueCross BlueShield of North Carolina

New Benefit Changes on the Horizon for 2003

P F A Rx

BCBSNC will be making several benefit changes in 2003. These changes will affect the following products–Blue Options℠, Blue Choice®, Blue Care®, and Classic Blue®. Please note that we will be staggering our implementation of benefits in 2003. New drug benefits will be introduced for all groups with a renewal date of January 1, 2003, or after.

New Copayments

Several new health benefit options will be available to all groups as of April 1, 2003, or upon their renewal date. Some of these changes include a new standard ER copayment of $150, new office visit copayments, and new routine eye exam copayments. The specific copayment for each of these services will be listed on the member's 2003 BCBSNC ID card.

Outpatient diagnostic services for Blue Options, Blue Care and Blue Choice members, such as laboratory tests and mammography, will be payable at 100 percent if performed alone. They will be subject to the member's deductible and coinsurance if they are performed with other services. All other diagnostic procedures–such as EEG's, EKG's, X-rays and imaging exams–will be subject to the patient's deductible and coinsurance when performed on an outpatient basis.

Diagnostic services performed in an office setting will continue to be covered at 100 percent after the office visit copayment has been taken, if applicable. A copayment only applies if there is an office visit service performed with diagnostic services. Otherwise, these services are reimbursed at 100 percent of allowable charges.

Blue Advantage® Benefit Changes for 2003

P F Rx

There will also be copayment changes in 2003 to our individual product, Blue Advantage. Most of these changes will be reflected on the member's BCBSNC ID card. Here's a quick reference guide regarding the changes to Blue Advantage Plan A and Plan B:

BLUE ADVANTAGE PLAN A

Prescription Drug Copayments will change from $10/$20/$30 to $10/$25/$40

Emergency Room (ER) Copayments will change from $100 to $150

Routine Physicals will no longer have a monetary limit

BLUE ADVANTAGE PLAN B

Prescription Drug Copayments will change from $10/$25/$40 to $10/$30/$45

Primary/and Specialist Copayments will change from $30/$45 to $25/$50

Emergency Room (ER) Copayments will change from $100 to $150

Routine Physicals will no longer have a monetary limit

New Home Infusion Policy

P A

BCBSNC will now allow coverage for a home infusion therapy (HIT) nurse to make additional visits for services needed other than the infusion visit therapy. The new policy is to encourage continuity of care by allowing the home infusion therapy nurse to return for additional visits when other services are needed such as wound care.

For example: A BCBSNC member requires one (HIT) nurse visit and two wound care nurse visits per day. The HIT nurse would perform wound care at the same time as the initial infusion visit and can also perform the second wound care-only visit scheduled for that day. The approval and claim would show two HIT nurse visits from the HIT provider for that date.

Number One Patient Dissatisfier: Time Spent Waiting in Exam Rooms

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

Recent survey results show that our members are generally happy with their access to care and are increasingly satisfied with the service they receive from BCBSNC. In 2001, 89.9 percent of members responding to the survey reported being satisfied or very satisfied with their overall care and attention from their doctor and BCBSNC.

Areas for Improvement

Members' responses also help us identify potential areas for improvement. For instance, recent survey results revealed that 88.4 percent of members were generally satisfied with the time required to get an appointment with their doctor for a routine visit. However, only 74.0 percent of members were satisfied with the amount of time spent in the waiting room after arriving for an appointment–a potential area for improvement.

Based on this feedback and anecdotal information which more specifically identifies the actual dissatisfier as time spent in the exam room waiting to be seen, we again encourage you to be acutely aware of how long your patients are left unattended in both the waiting room and the exam room.

If you have suggestions regarding the improvement of BCBSNC patient satisfaction with time spent in either the waiting room or the exam room, we would like to hear from you. You may submit suggestions either by email at **quality@bcbsnc.com** or in writing to the attention of:

Network Quality Coordinator, Quality Management
BCBSNC
P.O. Box 2291
Durham, N.C. 27707

Home Health Service Reminders

Access to in-home nursing and rehabilitative services (physical therapy, occupational therapy and speech therapy) is a valuable benefit for BCBSNC members. We would like to share with you the following reminders about what is and is not covered in regard to home health services:

- Blue Care, Blue Choice, Personal Care Plan℠ and Med*Point*℠ (our HMO and POS products) require prior Plan approval from BCBSNC for all home health services, except rehabilitative services. Approval must be obtained prior to services being actually rendered.

- To obtain authorization, please contact our Discharge Services nurses by calling **800-672-7897 (ext. 1910)**, or fax requests to us at **800-228-0838**.

  Members must be considered homebound (exception—home infusion therapy) to be eligible for in-home service benefits. The following criteria must also be met:

  - The patient requires physical assistance and significant supervision by another person in order to leave his/her residence and travel to a physician's office or outpatient treatment facility.

  - A physician has ordered treatments requiring nursing supervision of such frequency or duration that it is unreasonable to expect the patient to receive this supervision in an outpatient facility or a physician's office.

Please note that lack of transportation is not a medical criterion to be considered homebound.

Discharge Services staff is available to assist you with requests for services to HMO and POS members for home health, home infusion therapy, durable medical equipment (over $1500) and to assist you with arranging other services.

The complete BCBSNC Medical Policy for skilled, in-home services is available online at **bcbsnc.com**. Should you have any other questions about home health services, please contact our Customer Service Department via the Provider Blue Line℠ at **800-214-4844**.

Helpful Tips for Completing the W-9 Tax Form

We realize that the necessary paperwork related to Internal Revenue Service (IRS) information can be confusing at times to complete. BCBSNC is required by law to report all payments to the IRS. The Substitute W-9 form (or the IRS W-9 form) is the document we use to enter the tax information into our 1099 database for IRS reporting purposes. Here are some tips to guide you in completing the W-9:

- You'll find helpful information on the back of the BCBSNC Substitute W-9 form that can help you complete it accurately.
- "Tax Status" on the Substitute W-9 form refers to the tax entity under which you are filing taxes.
- An individual or sole proprietor tax status files taxes on Form 1040. The IRS can only match your individual name with your social security number (SSN) or employer identification number (EIN). They cannot match your "Doing Business Name" (DBA) or trade name with either your SSN or EIN.
- A sole proprietor must always use his/her individual name on the legal name of the business. This corresponds to the first line of the W-9 form and is the "Legal Name" on the substitute W-9 form and "Name" on the IRS W-9 form.
- Partnerships, corporations and other entities would use the name on the charter or other legal document used to create the entity, which was also on the original filing with the IRS to receive an EIN. This name would go on the "Legal Name" line on the Substitute W-9 form or the "Name" line on the IRS W-9 form.
- You can refer to preprinted labels from the IRS on documents such as payroll deposit coupons or income tax returns to verify the name and tax identification number that the IRS has on file for your entity. On either the Substitute W-9 form or the IRS W-9 form, we are looking for the information as it is currently on file with the IRS.
- If you are an individual or have sole proprietor tax status and you change your name, the Social Security Administration (SSA) must be notified. Generally, your local SSA office can assist you with changing your name and getting a new social security card.
- For any other tax status, the IRS must be notified when there is a name change. For instructions on how to change your name with the IRS or other questions, call the IRS toll free at **800-829-1040**.
- The "Legal Name" line on the BCBSNC Substitute W-9 form and the "Name" line on the IRS W-9 form refer to the name as it is on file with the IRS if you file using an EIN, or with the SSA if you use your social security number to file. The "Doing Business As Name" line on the Substitute W-9 form and the "Business" name on the IRS W-9 can be used for your business, trade or DBA name.
- Enter either your SSN or your EIN, but not both. This creates confusion as to which one is the correct one to use to report payments for 1099-MISC reporting.
- BCBSNC can only accept our own Substitute W-9 form or the IRS W-9 form (revised date January 1, 2002). If you have previous, out-dated versions of the IRS form completed, please use or Substitute W-9 form or current IRS W-9 form. You can download the latest version of any IRS forms from the IRS Web site at **www.irs.gov/**

Cranial Banding to Treat Positional Plagiocephaly

As of January 1, 2003, BCBSNC will be adding coverage for an orthotic helmet device to treat a condition affecting infants called positional plagiocephaly. Positional plagiocephaly is the asymmetrical shaping of the head either in the prenatal or postnatal environment due to uneven pressure on the skull. It is typically treated within the first year.

BCBSNC will cover the cost of orthotic helmets for treatment of positional plagiocephaly up to a lifetime maximum of $600. There are currently two types of helmet designed to re-shape the infant head. A "custom hard helmet" that is molded and fitted to the baby's head costs approximately $3000. A "soft helmet" costs between $200 and $300. The limited benefit is available for either type of device.

Imaging Services Added to Prior Plan Approval List (P) (F)

This past summer, BCBSNC mailed you a letter to let you know that select imaging services were being added to BCBSNC's prior Plan approval (PPA) requirements for our Blue Care, Blue Choice, and Blue Options products. The following select non-emergency imaging services now require authorization when rendered in a freestanding (office) setting:

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

Please note that there have been two important changes to the program:

1 The effective date of the program has changed since we last communicated with you on this topic. The new effective date is January 20, 2003. Beginning January 6th, physician offices may call National Imaging Associates directly at **800-642-7543** for authorizations and notification requests.

2 Prior Plan approval is only required for the services noted above when rendered in a freestanding (office) setting. Imaging services rendered in an inpatient or outpatient hospital setting will not require prior Plan approval at this time.

The program is targeted and does not require all physicians to obtain authorization through the prior Plan approval process. Physician practices will receive a letter prior to the program's effective date informing them as to whether their practice is required to obtain prior Plan approval or is initially exempt from the prior Plan approval requirement. Physicians who are initially exempt from obtaining prior Plan approval will only be required to provide notification of the imaging services that will be provided prior to the services being rendered.

It's important to note that all physicians referring a member for the services noted above must either request prior Plan approval or provide prior notification. Physicians rendering the above-noted imaging 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.

What We Learned From You About Menopause Counseling! (P)

Irrefutably, appropriate management is important in addressing the short-term symptoms and mitigating the long-term health risks associated with menopause. Because of the complexity and individualized nature of the treatment options to manage estrogen loss—particularly in light of the recent Women's Health Initiative (WHI) findings—both the U.S. Preventive Services Task Force and the American College of Obstetricians and Gynecologists recommend that peri-menopausal women should be counseled and fully informed of the risks and benefits of, and alternatives to, HRT. As you well know, ultimately, the choice about HRT or other management techniques should evolve through a collaborative decision-making process between you and your patient that results in an individualized plan to treat the symptoms and prevent the long-term effects of menopause.

Many providers are doing an excellent job of facilitating this process. However, based on self-report, a segment of Blue Cross and Blue Shield of North Carolina female members of peri-menopausal age (age 45 to 55) reported no exposure to counseling (18.8 percent) in 2001. Without exploring root causes, it is difficult to determine what barriers may be impacting menopause counseling. We don't know if they stem from health behaviors on the part of women (i.e., not establishing a relationship with a regular doctor), or from other factors like lack of time during office visits, or the complexity of the health issue. For this reason, we decided to ask you, our providers, what you think, so that we can better plan menopause-focused interventions that are effective and useful in helping you provide quality care.

(See Menopause Counseling on page 7)

Menopause (continued)







From the Source –

In recent telephone interviews with a sample of primary care and OB/GYN physicians, we asked a series of questions related to menopause counseling. Here is what we learned:

- **Counseling frequency?** The majority of the physicians polled indicated they had an opportunity to counsel peri-menopausal women daily.
- **How does the topic of menopause come up?** Patients usually raise the topic of menopause, although sometimes physicians bring it up during a physical examination while obtaining a medical history, or in the context of discussing osteoporosis screening.
- **What are the barriers?** Lack of time, the complexity of the issue, lack of clear information about what to recommend, patients' fears about HRT, and lack of availability of appropriate educational material.
- **What types of menopause counseling have physicians been involved in?** Most physicians interviewed had only been involved in individual counseling, but a few had also participated in group discussions or given lectures.

The key messages women need to hear are:

- How to reduce long-term risk (heart disease and osteoporosis prevention)
- What symptoms to expect
- Methods available for managing these symptoms
- The pros and cons of HRT
- The importance of exercise and a healthy diet
- And that menopause is a normal transition and part of the life cycle.

- **Tools for patients that would be helpful for providing menopause counseling:** Short, simple pamphlets and/or information that is easy to understand; materials that are culturally appropriate and balanced, presenting an array of management options; pre-assembled packets to give women; and information for waiting rooms.
- **Tools for physicians that would be helpful for providing menopause counseling:** Counseling reference tools (e.g., a laminated checklist of topics to cover), clinical practice guidelines, and CD-ROMs or videotapes.
- **Advice for program development:** Ensure there is a balance of pharmaceutical and alternative/lifestyle management options presented; summarize the WHI findings carefully; keep it simple; have clear guidelines.
- **What to avoid:** Advocating unproven therapies or definitively recommending HRT, using branded materials–above all, avoid a one-size-fits-all approach.

Thank you to the physicians who gave their time and shared their insights to help us better work with you on improving menopause counseling for our female members. The data gathered is invaluable and will serve as the foundation for developing future strategies to address this important women's health issue. If you have other ideas or thoughts that could help us in planning a menopause initiative, please email us at **quality@bcbsnc.com**.

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.

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 Plan No Longer Exempt from Prompt Payment Mandate

During the 2000 legislative session, the North Carolina General Assembly established legal requirements for the prompt payment of medical claims. The State Health Plan was exempted from the prompt payment mandate until December 31, 2002.

Effective January 1, 2003, the State Health Plan will be required to take one of six actions within 30 days of receiving a claim from a health care provider or facility:

1. Pay the claim.
2. Deny the claim.
3. Notify the claimant that there is insufficient information to process the claim.
4. Notify the claimant that the claim was not submitted on the appropriate form.
5. Notify the claimant that coordination of benefits is needed to pay the claim.
7. Notify the claimant that the claim cannot be processed due to nonpayment of fees by the patient's employer.

Claims adjudicated after the statutory limit (30 days) will be subject to an 18 percent annual interest rate. The State Health Plan must inform the insured of the claim status if it remains unpaid after 60 days and send a status report to the insured and the claimant every 30 days thereafter until the claim is resolved.

State Health Plan News and Helpful Reminders

P F A Rx

Claims Sent to Wrong Address Will Be Mailed Back

Effective January 1, 2003, claims for regular BCBSNC business that are sent in error to the State Health Plan will be mailed back. We will no longer send them to BCBSNC on your behalf. Please make a note in your office that State Health Plan claims (other than prescription claims) MUST be mailed to:

State Claims Processing Contractor
P.O. Box 30025
Durham, N.C. 27702

New Information on State Notification of Payment

The State Health Plan Notification of Payment now has a copayment and coinsurance column. Copayment amounts will no longer be placed under the "No covered/disallowed" column. The change went into effect with all State Notification of Payments generated since the end of September.

Coordination of Benefits and State Health Plan Coverage

Please note that when the State Health Plan is the secondary insurance carrier, coordination of benefits applies to all inpatient and outpatient claims. The Plan will reimburse up to contracted charges.

A Reminder about State Health Plan Chiropractic Benefits

Under the State Health Plan, chiropractic benefits are limited to X-rays, manipulation, and modalities of the spine, back and neck region. Benefits are limited to $2,000 per fiscal year per patient and to no more than one hour per day.

Services are also subject to the $350 Plan year deductible and payable at 80 percent after a $15 copayment per date of service. Supplies, drugs, creams, foot orthotics, acupuncture and durable medical equipment provided by a chiropractor are not covered.

State Health Plan Prior Approval Forms

P F A Rx

In order for us to process your prior approval requests for services on behalf of State Health Plan and NC Health Choice for Children members, it's important that you include the following information on the prior approval form:

- Patient name, ID number and diagnosis
- Provider name and address
- BCBSNC provider number or tax ID number
- Provider fax and telephone numbers
- A clear statement of the services requested (including CPT or HCPC codes), dates of service, and the medical necessity documentation to support your request.
- For home health, physical therapy, occupational therapy, and speech therapy, please include frequency of services, plan of treatment and goals.
- For surgical procedures, indicate place of service.

Mail information to:	Fax information to:	Fax Numbers:
Medical Review Requests ATTN: PRIOR APPROVAL P.O. Box 30111 Durham, N.C. 27702-30111	Hospital Pre-Certification Requests (inpatient hospital and acute rehab)	919-765-4891
	Prior Approval Requests	919-765-4890

Need more information?

For Hospital Pre-Admission Certification, Call: 800-672-7897

For Prior Approval, Call: 800-422-1582

You may print out copies of the prior approval form from the State Health Plan Web site at statehealthplan.state.nc.us

Introducing Federal Employee Program Benefits for 2003 PFA Rx

Here is a quick reference guide that outlines the benefit changes to both the Federal Employee Program (FEP) Standard Option and Basic Option plans for 2003:

Benefits	2003 FEP Standard Option Coverage	2003 FEP Basic Option* Coverage
Hospital / Facility Care		
Hospital Inpatient- Precertification required	◎ $100 copayment per admission for unlimited days	◎ $100 per day up to $500 for unlimited days
Outpatient Facility Care (except outpatient surgery)	◎ 10% of the Preferred Provider Allowance (PPA) ◎ Subject to $250 calendar year deductible	◎ $30 copayment per day
Outpatient Surgery	◎ 10% PPA	◎ $30 copayment
Emergency Care		
Accidental Injury Care Physician and Facility Care	◎ No expenses for covered charges for services rendered within 72 hours of onset	◎ $50 copayment
Preventive Care		
Preventive Screenings and related office visit charge, routine physical exams	◎ $15 office visit copayment ◎ No expenses for covered charges	◎ $20 office visit copayment for primary care provider ◎ $30 office visit copayment for specialists ◎ No expenses for covered charges
Screening Colonoscopies	◎ 10% PPA ◎ Subject to $250 calendar year deductible	◎ $100 copayment per surgeon
Physician Care		
Inpatient Services, including surgery, medical care, and outpatient surgery	◎ 10% PPA ◎ Subject to $250 calendar year deductible	◉ $100 copayment per performing surgeon ◉ No expenses for other covered services
Home and Office Visits, Second Surgical Opinions and Consultations	◎ $15 office visit copayment	◉ $20 office visit copayment for primary care provider ◉ $30 office visit copayment for specialists

BlueCross BlueShield of North Carolina

Benefits	2003 FEP Standard Option Coverage	2003 FEP Basic Option* Coverage
Prescription Drugs		
Mail Service Pharmacy	◎ 21 to 90-day supply ◎ $10 copayment for generic drugs ◎ $35 copayment for brand-name drugs	◉ No benefit
Retail Pharmacy	◎ Up to a 90-day supply ◎ 25% PPA at time of purchase	◎ Up to a 34-day supply ◎ 90-day supply for three copayments ◎ $10 copayment for generic drugs ◎ $25 coypayment for formulary brand-name drugs ◎ 50% coinsurance ($35 minimum) for nonformulary brand-name drugs
Mental Health and Substance Abuse Care		
Outpatient Professional Services	◎ $15 office visit copayment	◉ $20 office visit copayment
Chiropractic Care		
Spinal Manipulations	◎ No benefit	◉ Up to 20 spinal manipulations per year ◉ $20 copayment
Other Benefits		
Catastrophic Benefits	◎ 100% payment level begins after the member pays $4000 out-of-pocket in coinsurance, copayment and deductible expenses	◉ 100% payment level begins after the member pays $5000 out-of-pocket in coinsurance, copayment and deductible expenses

This is only a summary of the benefits for the 2003 Blue Cross and Blue Shield Service Benefit Plan. All benefits are subject to the definitions, limitations and exclusions set forth in the 2003 federal brochure. You can also visit our Web site at **fepblue.org** or call our Customer Service Department at **800-222-4739**.

Basic Option Highlights–please note the following:

Benefits available for preferred providers only.

- Primary providers include general practitioners, family practitioners, medical internists, pediatricians and obstetricians/gynecologists.
- Benefits are only available for care provided by nonpreferred providers in certain situations, such as emergency care.

FEP Update: Injectable Drug Network

In March of 2002, BCBSNC began offering an injectable drug network to supply you with select injectable drugs for the treatment of your BCBSNC patients. We are pleased to announce that Federal Employee Program members are now included in the program when they receive services in the state of North Carolina. (Please note that Medicare Supplement subscribers and State Health Plan members are excluded from this network. Please continue to obtain injectable drugs for these patients through your current process.)

The goals of the program are to:

1. improve access to and simplify the process of obtaining select injectable drugs,
2. to streamline the submission of injectable drug claims, and
3. to provide a cost-effective service for you and our members.

Use of the Network is Voluntary

You can order member-specific injectable drugs from network vendors and have them shipped to your office. Vendors will accept orders up to seven days prior to the patient's appointment (delivery is guaranteed and most orders can be delivered within 24 to 48 hours).

Network vendors will bill BCBSNC directly for the injectable drug; thereby 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. IF YOU ORDER ONE OF THE INJECTABLE DRUGS FOR A BCBS FEDERAL EMPLOYEE PROGRAM MEMBER FROM A NETWORK VENDOR DO NOT FILE A CLAIM WITH BCBSNC FOR THE DRUG. THE VENDOR WILL BILL BCBSNC DIRECTLY FOR THE DRUG.

Further information and updates on the program can be found in the "Provider" section of our Web site at **bcbsnc.com**.

We are pleased to offer this resource to you and we will continue to evaluate opportunities to enhance the program. 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.

The Impact of HIPAA on HEDIS Medical Record Review

New privacy regulations under HIPAA, the Health Insurance Portability and Accountability Act of 1996, will affect reporting for the National Committee on Quality Assurance (NCQA) accreditation and monitoring of quality initiatives. The following Q&A helps explain HIPAA's impact on Blue Cross and Blue Shield of North Carolina's (BCBSNC's) efforts to collect data on quality measures from physician offices.

What is involved in NCQA quality reporting? NCQA uses a system called HEDIS, or Health Plan Employer Data and Information Set, for accreditation and monitoring of quality initiatives. BCBSNC's quality management consultants visit physician offices to collect data on quality measures – such as immunizations and mammograms – for a selected sample of our members.

How does HIPAA impact HEDIS? The final modifications to the HIPAA Privacy Rule published in August permit physicians to release protected health information to another HIPAA-covered entity (such as BCBSNC) for health care operations – including quality assessment and improvement activities – without authorization from the patient, provided that BCBSNC and the physician have or had a relationship with the member.

How will BCBSNC comply with the Privacy Rule during HEDIS data collection? For each HEDIS quality measure, BCBSNC randomly selects members enrolled in a BCBSNC HMO or POS Plan for each quality measure in HEDIS. Our Quality Management department then reviews protected health information for BCBSNC members who meet the HEDIS selection criteria. BCBSNC is held to a standard of reviewing the minimum necessary information in the medical chart to fulfill the purpose of the review. Internal sanctions have been developed that apply to any employee who violates the Privacy Rule.

What is the definition of "minimum necessary?" BCBSNC quality management consultants have a limited set of questions for each measure. They will only research and collect information that relates directly to the quality measures. The time period reviewed is related to the measure for which the member was selected. For example, in the cervical cancer screening measure, we check the chart for a pap smear performed within the past three years. However, we also check the chart to assure that the woman did not have a complete hysterectomy in her medical history, which would make her ineligible for the measure.

More Questions? Email us at **quality@bcbsnc.com**. For general HIPAA information, you may contact the North Carolina Healthcare Information and Communications Alliance at **www.nchica.org** or the Department of Health and Human Services at **www.hhs.gov**.

Claim Tips for Multiple Contract or Border County Providers

Do you practice in a county that borders another state? Do you contract with multiple Blue Cross and Blue Shield Plans? If you answered yes to either of these questions, take a look at these tips that will help you file claims for Blue Plan members.

Multiple Contract Providers

If you practice in a state with more than one Blue Plan and you contract with more than one Blue Plan for the same product type, like PPO for example, then you may choose which Plan to submit an out-of-area Blue Plan member's claim to for consideration. If you have a PPO contract with one Plan and a Traditional contract with the other Plan, file the out-of-area claim to the Plan with the patient's product type.

Border County Providers

If you practice in a border county, always file the claim to the Blue Plan located in the state in which you provided the services in question. The one exception to this standard rule is that if the member is from a bordering Blue Plan with which you have a contract, then file the claim directly that bordering Plan. Please contact your BCBSNC Network Management representative if you have further questions.

BlueCard® Medical Records Management Process Improves

Thanks to your valuable feedback, BlueCard has improved its medical records management process to better serve you. Look for these improvements with the new process:

- **Number of Requests Reduced** – Changes to our internal medical records procedures will eliminate unnecessary requests, thus expediting claims processing for BlueCard members and providers.
- **Clearer Instructions** – A reader-friendly form will accompany all medical records requests to facilitate claims processing.
- **Better Tracking and Improved Claims Turnaround Time** – BlueCard will have designated units to receive medical records and will implement a new tracking procedure to better coordinate medical records throughout the claims process.

Stay tuned for more details in the coming months. In the meantime, please continue to call BlueCard Customer Service at **800-487-5522** for questions regarding medical records.

Our Privacy Policies

At Blue Cross and Blue Shield of North Carolina (BCBSNC), we take very seriously the privacy interests of our members, as we know you do. In connection with recent developments concerning the law of privacy, we are updating existing policies and developing new policies and procedures to comply with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The highlights of our policies are described below. As contracting providers, we want you to understand how we safeguard our members' information.

We protect all personally identifiable information we have about our members, and disclose only the information that is legally appropriate. Our members have the right to expect that their legally protected privacy interests will be respected and protected by BCBSNC.

Our policies are intended to comply with current state and federal law, and the accreditation standards of the National Committee for Quality Assurance. If these requirements and standards change, we will review and revise our policies. We also may change our policies (as allowed by law) as necessary to better serve our members.

(Please see Privacy on page 15)

BlueCross BlueShield of North Carolina

Privacy (continued)

Privacy Principles

To make sure that our policies are effective, we have designated a Chief Privacy Official and a Privacy Committee that are charged with approving and reviewing the Plan's privacy policies and procedures. They are responsible for the oversight, implementation and monitoring of our policies.

Here are our fundamental privacy principles:

- We will protect the confidentiality of protected health information about our members and will not disclose any protected health information to any external party except as we describe in our Notice of Privacy Practices or as permitted or required by law or regulation.
- Each of our employees must sign a confidentiality statement when they begin work with us, stating that they will abide by our privacy policies. Only employees who have legitimate business needs to use members' protected health information will have access to such information.
- When we use outside parties to perform work for us, as part of our insurance business, we require these contractors to an agreement, stating that they will protect members' protected health information and will only use it in connection with the work they are doing for us.
- We also require the same kind of confidentiality agreement with our contracted physicians.
- We communicate these policies to our members; both through member magazine articles and during the enrollment process they follow when becoming a Plan member.
- We will disclose personal information only where:
  - required or permitted by law; or
  - the subscriber has consented to disclosures as part of the enrollment process; or
  - we obtain a separate authorization from the member for specific purposes.

Disclosures Permitted by Law

Most of the disclosures that we make are permitted or required by law, or the member has consented to the disclosure as part of the enrollment process. These disclosures include those for health care treatment and payment, our company's health care operations as authorized by law, various areas where the member's consent is not needed for certain public purposes (such as public health emergencies) and certain other health care purposes such as coordination of medical care, quality assessment and measurement and accreditation. In a limited number of situations beyond these areas, we will seek a member's separate authorization for a specific purpose.

- Members have the right to review certain records held in our possession. If a member wishes to review records containing information about them, they must submit a written request for copies of the information (we may charge a fee to obtain these copies).
- If the member has questions or concerns about the accuracy or completeness of information we have about them, the member should contact us in writing, to tell us about their concerns. We will make the appropriate changes, as may be required by law. If a physician, other medical provider, or someone other than us created the information, then we will direct the member to that person to make the corrections.
- We may send some information to employers that provide health care benefits to their employees. In most situations, this information will not identify a specific individual. Instead, it will be summary information, or information in another form where the personal identifiers have been removed.
- If we do need to disclose identifiable information to an employer, than we will require the employer to agree that this information cannot be used in connection with any decisions about the employee, for example, in connection with the employee's job. This information also will be provided only to a very limited number of people within the member's company, mainly the people that help with the administration of the employee benefits plan.

BCBSNC Standards for Urgent Care Centers

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

1 A credentialed "urgent care physician" must be on site during all hours of operation. The following specialties can be credentialed as urgent care physicians:

- Family Medicine
- Pediatrics
- Internal Medicine
- Emergency Care

Other specialties, as determined by the Credentialing Committee, may be accepted as urgent care physicians. Additionally, a supervision policy in compliance with state regulations must be in place for all mid-level practitioners employed at the site.

2 The practice has an established quality improvement process in place, which includes the following:

- Quality Improvement Committee meetings will be held at least every six (6) months with minutes of meetings.
- Care processes and outcomes monitors are appropriate for the practice.

3 The practice has written policies and procedures in place that effectively preserve patient confidentiality. The policies specifically address:

- How informed consent is obtained.
- How personal health information currently existing or developed during the course of treatment is released to an outside entity, i.e., primary care physicians, specialists, hospitals, third party payers, state or federal agencies.
- How informed consent for the release of medical records is obtained, including current and previous medical records from other providers, which are a part of the medical record.

In addition, medical records must be secured and be accessible only to authorized office/medical personnel.

4 The practice must have the following patient safety measures/equipment in place:

- Appropriate CPR equipment and the ability to perform advanced life support in a timely manner.
- Transportation policy for critically ill patients or medical emergencies.
- Restricted or abusable materials, i.e., drugs, needles, syringes are secured and accessible only to authorized office/medical personnel.
- Dedicated emergency kit is available which must include sufficient equipment/supplies to support life until the patient can be moved to an acute care facility.
- Procedures to clean equipment must be in place.
- A fire extinguisher must be clearly visible and readily available.
- A smoke-free environment is promoted and provided for patients and family members.
- Halls, storage areas, and stairwells are neat and uncluttered.
- The evacuation plan is posted in a prominent place or the exits are clearly marked and visible.
- Medical records are legible to someone other than the author.
- The patient's allergies are prominently displayed.
- The patient's name is on every page.

5 The facility, which includes the reception area, exam rooms, nurses station, is neat and orderly.

6 There are clearly marked parking spaces and easy access to the building for the physically challenged.

7 There is a private area for confidential discussions with patients.

8 Designated toilet and bathing facilities are easily accessible and equipped for the physically challenged.

9 Doors are of sufficient width (28 inches minimum) to accommodate EMS personnel and equipment.

10 Medical records will include, at a minimum, the following documentation:

- History of current illness/ injury
- Care medically appropriate
- Physical status
- Date of visit noted
- Diagnostic data appropriate and included in record
- Entries signed by provider

Blue Link News and Time-Saving Reminders

Grange Discontinuance

Effective January 1, 2003, BCBSNC is discontinuing its group health program for members of the Grange. We have worked with the Grange to make sure this transition is as smooth as possible. Members currently participating in the program will be offered guaranteed coverage under our popular Blue Advantage® product for individuals.

Employer Groups Transitioning from PARTNERS to BCBSNC

Effective January 1, 2003, the following large employer groups will be transitioning from PARTNERS to BCBSNC; therefore, their employees' benefits will changing to a BCBSNC plan:

Charlotte Region	Piedmont Natural Gas
Raleigh Region	Rex Healthcare Wake Med Allstate
Triad Region	Novant City of Winston-Salem (2/03) Polo Ralph Lauren Davie County Ingersoll Rand Aetna Atrium (Ellison Windows and Doors) PPG

Emergency Room Services

Charges for an emergency room visit or services that result in an approved 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 on a UB-92 with a bill type of "13J" 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.

Credentialing

BCBSNC credentials providers participating in all of our managed care products. Our Credentialing Committee reviews in depth any practitioner identified as having potential issues that may result in decredentialing. If decredentialing is deemed appropriate in a given case, the provider is informed of their right to appeal including–but not limited to–a review of the information submitted in support of their credentialing application.

Only National Codes Now Accepted

As of October, we can 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.

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 a denied inpatient admissions will continue to process according to prudent layperson criteria.

New BlueCard PPO Members

Effective January 1, 2003, BOISE members currently enrolled under an HMO Plan will be covered under BlueCard PPO. Prior to this effective date, new ID cards will be issued with the alpha prefix "**RPP**." All claims with dates of service on or after January 1, 2003, should be submitted with the new alpha prefix of "**RPP**." To avoid delays and possible denial of claims, it is critical that you file all claims with the correct prefix.

BlueCross BlueShield of North Carolina

Rx Corner

Drugs to be Added to HMO Prior Approval List

Prior approval is a prospective drug utilization program that encourages the appropriate use of a prescribed drug. Currently, only BCBSNC members with Personal Care Plan or Blue Care (our HMO products) must have approval for a limited number of drugs prior to coverage.

Effective January 1, 2003, three new drugs—Arava, Enbrel and Kineret—will be added to the prior approval list for Personal Care Plan and Blue Care. To minimize inconvenience to both you and our members, our pharmacy claims system will allow automatic authorization for Arava, Enbrel and Kineret when a member's drug history establishes that clinical coverage criteria have been met. Please visit **bcbsnc.com** for more details on our drug utilization management programs.

Tier Changes for Non-Sedating Antihistamines

In anticipation of a final ruling by the FDA granting over-the-counter (OTC) status to the entire family of Claritin products, Blue Cross and Blue Shield of North Carolina is announcing a change in our coverage of non-sedating antihistamines. Effective January 1, 2003, all prescription non-sedating antihistamines will be moved from a Tier 2 to Tier 3 copayment level. These drugs include Allegra, Clarinex, and Zyrtec. Additionally, Claritin products will no longer be covered after loratadine is introduced on the OTC market.

Limit Set on Erectile Dysfunction Drugs

Effective December 1, 2002, members who have Personal Care Plan, Med*Point*, Preferred Care *Select*® *Copay*, Blue Care, Blue Choice, Blue Options, and Classic Blue® will have a limit of four therapeutic units per 30-day supply of drugs used to treat erectile dysfunction (e.g., four Viagra tablets per 30-day supply). Drugs such as Viagra, Muse, Caverject and Edex are all classified under this limit. The purpose of the new limit is to help ensure appropriate utilization and to conform more closely with national benefit trends. Members who have received a prescription for one of these drugs greater than the four therapeutic treatment supply in the last 12 months were notified by mail of the change in quantity limits.

Methadone Maintenance

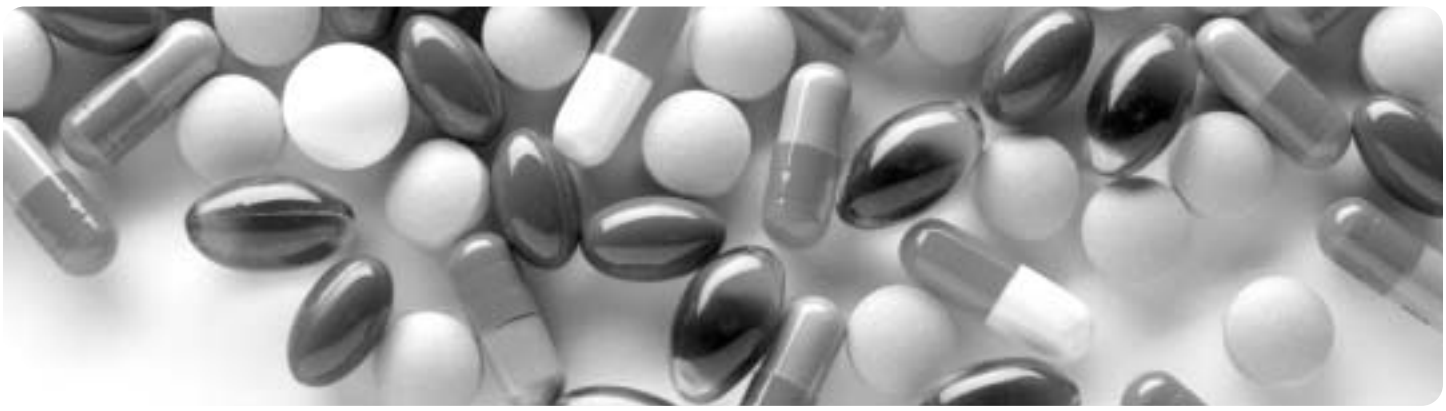
Please be advised that BCBSNC benefits do not typically cover methadone maintenance. For further clarification of benefits, please call the Provider Blue Line at **800-214-4844**.

Infliximab Coverage Update

BCBSNC provides coverage for Infliximab, which is a second-line drug therapy typically used to treat Crohn's Disease or rheumatoid arthritis, when it is determined to be medically necessary and the medical criteria and guidelines in the corporate medical policy are met.

Effective December 1, 2002, we began reviewing all Infliximab cases to ensure that usage meets our medical necessity guidelines. Use of Infliximab that does not conform to our medical policy may result in a denial for reimbursement.

If you have questions regarding this update, please contact your local Network Management field office. The medical policy for the usage of this drug can be found at **bcbsnc.com**.



Accessing BCBSNC Member Eligibility Data

P F A

BCBSNC now provides our health care providers with full scope, unlimited, real-time eligibility information over the Internet – free-of-charge, via the **Blue *e***℠ interactive network. Using **Blue *e***, you can perform the following functions:

- Search for patient's ID number by name.
- Obtain information on health & dental eligibility for BCBSNC and State Health Plan members as well as eligibility for North Carolina Medicaid recipients.
- View status of submitted claims including BlueCard claims submitted to BCBSNC.
- View the last seven days of written check information.
- Enter claims, obtain daily claim listings and correct EDI front-end claim errors.
- View and print EDI bulletins & announcements.

Information Security and Data Sharing Changes

BCBSNC has decided not to renew existing agreements to share eligibility data with non-affiliated third-party vendors. New HIPAA privacy regulations, combined with our ability to provide access to real-time eligibility information, required us to review these agreements.

As a result, we will not renew our existing agreement with MedData when it expires at the end of 2002. Please remember that BCBSNC provides access to our complete and current member eligibility data–free of charge– via the **Blue *e*** interactive network.

If you do not already have the capability in your office to access BCBSNC member eligibility via **Blue *e***, please contact your EDI Services representative or call us at **888-333-8594**, **option 1**. You may also visit our EDI Web site at **bcbsnc.com/providers/edi** to access and print EDI materials.

EDI Leads in Technology Innovation

P A

BCBSNC EDI Services recently began work with a special committee of the North Carolina Medical Group Managers on electronic transaction and connectivity opportunities. BCBSNC remains committed to working on solutions that eliminate paperwork hassles and increase the accuracy and efficiency of transactions for our providers. Although the percentage of electronic claim transactions that we conduct with physicians and hospitals exceeds the national average, we recognize the desire of the medical community for a single solution for electronic transactions. We are not there yet, but we are eager to work cooperatively toward that goal. In the meantime, we offer electronic solutions that lead the industry in functionality.

- **Direct Connection** links BCBSNC to over 15,000 health care providers and 132 hospitals in North Carolina for no charge, batch-claim submission. We are currently piloting an electronic batch solution that will allow physicians to verify patient eligibility for BCBSNC and State Health Plan members in conjunction with scheduled appointments.
- Our **Blue *e*** product is in use at 886 physician practices – representing more than 12,000 doctors – as well as 132 hospitals, 262 ancillary providers, and 45 billing services. We recently moved Blue *e* to the Internet and eliminated all fees for providers. Blue*e* allows eligibility verification, electronic claim submission, claim status checks and online claim error correction. It also allows administrators to access benefits and administrative information online.
- In partnership with **RealMed Corporation**, we are deploying technology to physician practices that allows eligibility to be verified, claims to be edited, adjudicated and resolved, and an EOB to be printed–all before the patient leaves the doctor's office. We believe this "real time" solution offers real promise to our provider network. RealMed now reaches over 2,000 North Carolina physicians in 17 practice sites.

We are pleased with the progress we are making in implementing technology to simplify the claims resolution process for our members, as well as doctors and hospitals. If you need more information on the electronic connectivity that BCBSNC provides for your operation, contact your local BCBSNC EDI Services field consultant.

BlueCross BlueShield of North Carolina

BlueLINK

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