BlueLINK℠

News from Blue Cross and Blue Shield of North Carolina

Spring 2003

Volume No. 8, Issue No. 1

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bcbsnc.com

BlueCross BlueShield of North Carolina

Your Healthy Best® Now Targets Five Conditions

Blue Cross and Blue Shield of North Carolina (BCBSNC) is now offering a new and improved *Your Healthy Best* health management program to our members who suffer from migraine headache, fibromyalgia, irritable bowel syndrome, Crohn's Disease, and ulcerative colitis. As a participant in this program, members will receive comprehensive educational materials, condition-specific diaries, progress assessment tools, a health organizer, and personalized support from registered nurses to help complement and reinforce the care they receive from you, their physician.

Each of these conditions can significantly affect your patients' quality of life, productivity, and may even be the cause of work or school absenteeism. One of the primary reasons that patients do not follow their doctors' treatment plans is due to a lack of knowledge about their condition. Let us spend some time with your patients to help fill in their knowledge gaps, make them aware of available support groups, and if appropriate, educate them about other proven complementary therapies, such as massage or biofeedback, that will improve their quality of life and comply with your recommended treatment plan.

Look for the article "Enrolling Your Patients in BCBSNC Health Management Programs" in this issue for information on how to enroll a BCBSNC patient in the *Your Healthy Best* program or one of our other targeted care management programs.

BCBSNC Offers New Health Management Program: Your Heart Matters℠

We are pleased to announce that on April 1, 2003, we will begin offering a new addition to our suite of health management programs. Called *Your Heart Matters*, this program will focus on congestive heart failure. The *Your Heart Matters* program is designed to help people manage their condition by complementing and reinforcing the care they receive from you. Participating members will receive free education and nursing support. Other program components include:

- The choice of one of the following books–
  - *Success with Heart Failure: Help and Hope for Those with Congestive Heart Failure*
  - *Congestive Heart Failure: What You Should Know*
- Convenient congestive heart failure management tools to help BCBSNC patients organize and keep track of their medications, salt & fluid intake and other important health information; a quarterly newsletter full of valuable information and health tips; and a 25 percent discount on selected blood pressure monitors, heart rate monitors, and scales.
- Program participants can work with a registered nurse who will provide personalized health education and support.
- Up to $100 reimbursement for smoking cessation programs or products[1] .

If you would like more information on the *Your Heart Matters* program, please call us at **800-218-5295**. To refer BCBSNC patients to the program, look for the article in this issue, "Enrolling Your Patients in BCBSNC Health Management Programs."

1 Participation in a smoking cessation program or the purchase of related products can occur only after the BCBSNC member has enrolled in the health management program.

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Enrolling Your Patients in BCBSNC Health Management Programs

In order to make it quicker and easier to enroll your *BCBSNC* patients in our health management programs, we now offer the enrollment survey online for the *Your Asthma Care*, *Your Diabetes Care*, *Your Healthy Best*, *Your Heart Matters*, and *Your Baby & You*SM programs. All programs are confidential and free to members.

If you have a patient who would benefit from one of these programs, we have three options of enrollment available for your convenience:

1. Download the PDF version of the enrollment survey from **bcbsnc.com** and have your patient complete the survey. Just mail or fax it to us at:

   Mail the survey to: **BCBSNC**
   Population Health Management
   P.O. Box 30004
   Durham, NC 27707-9935

   Fax the survey to: **888-705-1018**

2. **Or**, you can fill out the short request form found under the "Member" portal on our Web site. We will mail your patient an invitation package, which will include the enrollment survey.

3. **Or**, Have your patient call us toll free at **800-218-5295**, and we will mail them an invitation package or give them the opportunity to complete the survey over the phone.

You may also notice some changes in our "Smoking Cessation" Web page. We are now offering an online smoking cessation guide that lists many resources available to those who want to quit. This informative resource includes contacts for support to help your patients reach their smoking cessation goals.

Rx Corner

You May Hear About Alavert From Our Members

Alavert is a new over-the-counter (OTC) nonsedating antihistamine with the same active ingredient as Claritin (loratadine). BCBSNC is providing members that use nonsedating antihistamines with coupons and information about Alavert and its availability without a prescription. Because all covered prescription nonsedating antihistamines are now on Tier 3 of BCBSNC's prescription formulary, most members will save money by using Alavert or other OTC loratadine products such as Claritin.

Generic Substitution Reports for Pharmacists

In an effort to help pharmacists better evaluate their generic substitution rate (GSR), we are sending new reports to all participating pharmacies showing their GSR and the average GSR of nearby pharmacies. Increasing your GSR will improve your net profitability, reduce out-of-pocket expenses for your patients, and will reduce the overall cost of prescription drug programs. Look for your first letter with your GSR information this spring.

Tier Changes for Calcium Channel Blockers

Effective February 1, Norvasc and Plendil were moved from a Tier 2 to Tier 3 copayment level. These changes resulted from a recent clinical review by the BCBSNC Prescription & Therapeutic Committee of published peer-reviewed data regarding the calcium channel blocker class of medications. For BCBSNC members with a three-tier benefit, therapeutic alternatives available on Tier 1 or Tier 2 may provide more clinically appropriate and cost-effective choices.

ePocrates

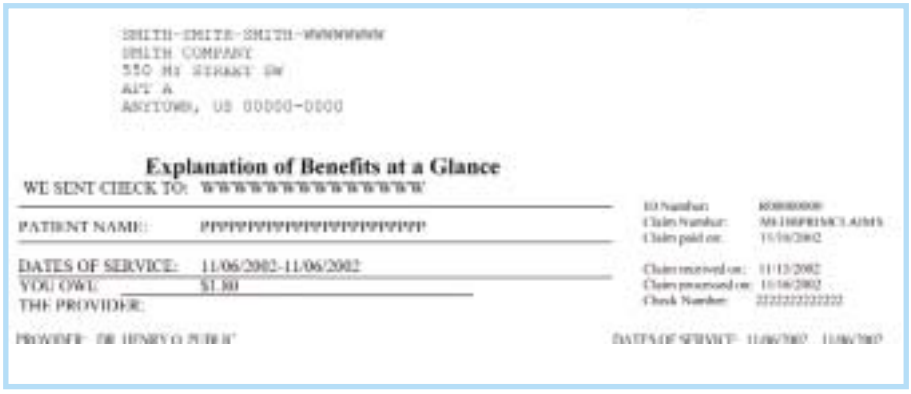
Did you know that the Blue Cross and Blue Shield of North Carolina formulary can now be downloaded to your handheld computer (PDA)? ePocrates Rx is a software program that can be downloaded free of charge for your use on Palm OS PDAs. This electronic drug reference software lets you search for clinical information as well as health plan-specific formulary information, such as copayment tiers. For more information about ePocrates, follow the "Download Formulary to PDA" link on our online Prescription Drug Search at **bcbsnc.com**.

Rx Formulary Updates

As of October 11, 2002:	
Bravelle	Added to Tier 2
As of January 1, 2003:	
Frova	Added to Tier 2
Zomig	Added to Tier 2
Foradil	Added to Tier 2
Hepsera	Added to Tier 2
Novolin (all Novo insulin products)	Added to Tier 2
Novolog	Added to Tier 2
Arava	Added to Prior Approval list
Enbrel	Added to Prior Approval list
Kineret	Added to Prior Approval list
Allegra, Allegra-D	Added to Tier 3
Clarinex	Added to Tier 3
Zyrtec, Zyrtec-D	Added to Tier 3
Claritin, Claritin-D	No longer covered as a prescription drug benefit; now available over-the-counter
As of February 1, 2003:	
Norvasc	Added to Tier 3
Plendil	Added to Tier 3

FEP: Enhancements to Explanation of Benefits Form

We have made it easier for Federal Employee Program patients to know their out-of-pocket responsibility for the services you render. One of the main enhancements on the new form is an "Explanation of Benefits at a Glance" box that indicates who received the benefit check, the patient's name, the date of service, and the amount owed to you, the provider. The provider's name field was also expanded to include your network status of preferred or nonpreferred. Also new are two boxes at the end of the EOB, which give a summary of the patient's out-of-pocket expenses, including their deductible, copayments, and coinsurance.



Now Available on Blue *e*℠

EDI Support Now on Line

EDI Services information is now online for your convenience. To access templates and information regarding our electronic connectivity options, just visit the EDI home page at **bcbsnc.com/provider/edi**. For assistance or questions related to electronic claims, real-time eligibility, electronic remittances, **Blue *e*** or any other health care provider electronic issue, you may also contact EDI Customer Support toll free at **888-333-8594**.

Eliminate The Hassle and Expense of Filing Paper Claims

Did you know that you can file claims directly to BCBSNC electronically? Doing so allows you to get your information to us quickly and correctly, so that your claims can process more quickly. To find out more about electronic claims filing, visit the EDI Web site or call us at **888-333-8594**.

BCBSNC Member Eligibility Data Available

Due to HIPAA privacy regulations, BCBSNC has made a decision not to share eligibility data through nonaffiliated third-party vendors. However, BCBSNC can provide you access to complete and current member eligibility data via the **Blue *e*** interactive network. This internet-based service is available to health care providers with no access fees. For more information or to sign up, please contact EDI Services at **888-333-8594**.

Blue *e* Network Now Available During Holidays

In late 2002, BCBSNC piloted an expansion of **Blue *e*** network availability during the Thanksgiving holiday when BCBSNC offices were closed to the public. The success of this pilot, combined with a positive response from the health care provider community, has resulted in permanent expansion of **Blue *e*** system access during all observed BCBSNC holidays. All **Blue *e*** applications will be available during normal business hours during these holiday periods. Claims entered on **Blue *e*** during holidays will be submitted for processing and reflect a receipt date of the next business day after the holiday period. BCBSNC is excited to provide this service to our providers during hours that your facilities and clinics may be in operation during a holiday period.

State Health Plan: Navigating the Appeals Process

Have you ever been denied payment for a claim, and you did not agree with the decision? According to the State Health Plan Appeals department, there are two common reasons why coverage for services may be denied under the State Health Plan:

- The service may not be medically necessary according to State Health Plan medical and administrative guidelines.
- The service is not covered under the patient's State Health Plan policy.

To determine whether or not a service is covered, contact State Customer Services at **800-422-4658** and a Customer Service representative will help you review the benefits in question. To determine whether a service or procedure is considered medically necessary, you can also visit our Web site at **www.nc-shp.com** to review the State Health Plan's medical policies.

If you still disagree with the decision, you can request a courtesy review. To begin the courtesy review process, call State Customer Services at **800-422-4658** or write us at P.O. Box 30111, Durham, NC 27702.

Members' Rights to a Formal Appeal

If after the courtesy review, you are still dissatisfied with the outcome, the member has the option of starting the formal appeals process. Since the State Health Plan must receive all written appeals within 60 days of a benefit decision, inquiries to Customer Services should be made as soon as possible. *Please note that appeals received after the 60-day time limit will not be considered. The 60 days begins with the date of the original benefit decision–not the courtesy review decision date.*

If someone other than the member wishes to submit the appeal, we must have an Authorization to Release Information form completed, signed, and notarized by the member. This form can be obtained by contacting State Customer Services. The member, or his or her designee, may begin the appeals process by submitting a written request to:

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

Levels of Review

Standard review means that the Claims Processing Contractor (CPC) handles the first and second levels of appeals review. Third level appeals review is handled by the State Health Plan Board of Trustees.

A State Health Plan member can request an *expedited review* if a delay would reasonably jeopardize their life or health or their ability to regain maximum function following illness or injury.

The process for mental health and chemical dependency appeals is the same as described above, except that the mental health case manager conducts the first and second level reviews.

Please note that North Carolina general statutes govern the Appeals and Grievances process. The State Health Plan member's benefit handbook is intended to summarize their rights under state law and is not intended to cover every individual situation. If any information in the handbook conflicts with state law, then North Carolina law will prevail.

Recent State Health Plan Appeals Decisions

Now that we've explained the appeals process, we thought you would be interested in some recent State Health Plan appeals and their resulting decisions. At the fall 2002 meeting of the Board of Trustees of the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, twenty-three appeals were heard. Here's a summary of the Board's decisions:

Removal of Bilateral Silicone Implants Services received in treatment of complications due to a previously performed cosmetic procedure are not covered if the complications were known at the time the noncovered services were provided.

Additional Payment for Claims Paid Based on Diagnosis- related Groupings (DRG)

The State Health Plan pays in-hospital benefits for each single confinement, when charged by a hospital, for room accommodations, including bed, board and general nursing care. Payment will not exceed the charge for semiprivate room or ward accommodations or the rate negotiated by the State Health Plan. Amounts exceeding DRG allowance are the member's responsibility when services are provided by a non DRG-contracting hospital.

Services the State Health Plan Deems Experimental

Benefits are excluded for the use of a service, supply, drug, or device not recognized as standard medical care for the condition, disease, illness or injury.

Gastric Bypass Surgery

Benefits are excluded for any care, treatment, services or supplies other than those required for the medically necessary treatment of the injury or disease.

Acupuncture Services Rendered by a Provider Licensed as an Acupuncturist

Acupuncture is covered only when performed by a medical doctor or doctor of osteopathy.

Request for Additional Usual, Customary and Reasonable (UCR) Allowance for Anesthesia Services

Pre-operative and post-operative anesthesia services are included in the flat charge for general anesthesia with the customary allowance based on the specific procedure based value of the procedure billed. Time is the only variable; therefore, benefits are limited to UCR.

Recent State Health Plan Appeals Decisions (continued)

Payment Reduced Because Member Refused Medicare Part B

If a State Health Plan member chooses not to enroll in Medicare Part B, the State Health Plan estimates the amount that Medicare would have paid for covered services and only considers the remaining balance for Plan payment just as if Medicare had paid.

Additional Skilled Nursing Facility (SNF) Benefits

Charges for care in a nursing home, adult care home, convalescent home, or in any other facility or location for custodial care or rest cures are excluded. Benefits for covered services are limited to the period in which the patient requires skilled nursing or rehabilitative services on a continuous daily basis.

Request for Home Maintenance Care

Services of the home care aide are to be considered as part of the overall treatment plan, as an adjunct to or extension of concurrent medically necessary skilled services.

Orthognathic Surgery

Orthognathic surgery is covered when specific prior approval requirements are met as outlined in State Health Plan medical policy.

Important State Health Plan Addresses

It is very important that you do not use regular Blue Cross and Blue Shield of North Carolina addresses or phone numbers for State Health Plan business, as it will result in claims being mailed back and unnecessary delays for both you and the patient. Please note the following addresses when contacting the State Health Plan:

Claims:
Claims Processing Contractor
P.O. Box 30025
Durham, NC 27702-3025

Correspondence:
State Health Plan
P.O. Box 30111
Durham, NC 27702-3111

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

Prior Approval:
State Medical Review : Prior Approval
P.O. Box 30111
Durham, NC 27702-3111

State Health Plan Claims Filing Reminders

P F A Rx

Red and White - Do It Right

When submitting HCFA 1500 and UB92 claim forms, it's important that you use the original red and white forms. Copied black and white forms cannot be read by our claims processing equipment and must be manually keyed, which results in processing delays.

Medicare Crossover Claims

We continue to receive a high volume of paper claims for State Health Plan members that have Medicare as their primary insurance carrier. Since these claims are submitted with the Medicare Explanation of Benefits (MEOB), they have to be researched to make sure the claims have not already crossed over to us from Medicare and previously processed. If you receive a MEOB with reason code MA18, which means the claim information is being forwarded to the patient's secondary insurance, please do not file a paper claim to the State Health Plan. Medicare will automatically forward the claim to us as the secondary insurer.

Secondary Reimbursement Filing Guidelines

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

Multiple Services on the Same Day

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

BlueCross BlueShield of North Carolina

Impacted Ear Wax Removal

The State Health Plan does not allow benefits for the removal of impacted earwax, CPT code 69210. Impacted earwax removal is considered to be an integral part of medical care and related surgery and is not covered separately.

Specimen Handling

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

ICD-9 Diagnosis Codes

All claims should be submitted with the appropriate ICD-9 diagnosis code and not just the verbiage. Ambulance providers should use an ICD-9 diagnosis code that is associated with the symptoms for the call since they do not provide an actual diagnosis.

We Need Your Help Verifying Provider Data

Our ability to successfully direct Blue Cross and Blue Shield (BCBS) Plan members to you for medical care depends on the accuracy of information that we obtain from you about your facility. To ensure that the information we have is up-to-date, please contact your BCBSNC Network Management field office representative to verify your information or provide us with any changes.

On behalf of the Blue Cross and Blue Shield Association and all Blue Cross and Blue Shield Plans, a vendor will be contacting a randomly selected list of providers to verify the information we currently have on file. They will request clarification of the following information:

- Provider name
- Provider specialty
- Provider address
- Telephone number for scheduling an office visit
- Treatment sites for patients

The company will verify this information with your front office staff. We suggest that you have your front office staff keep an updated provider roster handy, so they can easily provide accurate responses to the above questions. We appreciate your cooperation, as it will help to ensure that we can quickly communicate with you on important issues and updates.

BlueCard® and Medicare Cross-over Claims

We want to go ahead and make you aware of changes that will occur this October regarding BlueCard and Medicare cross-over claims. As of October 2003, Medicare supplement policies – with the exception of Medicare + Choice/Risk – will be designated by a three-digit prefix on the subscriber's ID card, and the claims will be processed through the BlueCard program or electronic claims routing process (ECRP).

Once this change takes place, other BCBS Plans should no longer ask you to file claims directly to them. They should only request a copy of the EOB if the information provided is questionable or they are not provided with the initial claim. Other Plans will be encouraged to request any additional information they need directly from BCBSNC.

How will this impact Medicare cross-over claims? You should continue to file your primary claim with Medicare and list the BlueCard subscriber ID number (including the alpha prefix) as the secondary coverage. Wait until Medicare sends you an EOB, which will show if the claim crossed over to the patient's home Plan. If it did, you should receive payment from the home Plan. If it did not, you'll need to file your claim to BCBSNC for processing through BlueCard or ECRP. If you have any questions, please contact our BlueCard Customer Service department at **800-487-5522**.

Online Services for Members with Magellan Benefits

Blue Cross and Blue Shield of North Carolina (BCBSNC) members who have mental health and substance benefits through Magellan Behavioral Health can now search for a provider online.

In late 2002, Magellan's member Web site, **MagellanAssist.com**, was enhanced to include an online provider directory, as well as many other useful tools.

Clinician Info Available

In order to access the online provider directory, members must first register online. No personal information is required from the member. Members can search for a clinician by either zip code or last name (using at least the first two letters of the last name). The information online includes the clinician's name, degree, address, and phone number. There's a separate page that explains the differences in educational backgrounds. If a member clicks on the "More Information" link, they will learn the clinician's areas of specialty, language(s) spoken, and the ages he or she treats in their practice.

This new service allows members to locate a clinician any time of day or night. Of course, if they prefer, they can still call Magellan's customer service center to locate a clinician in their area. **It is important to note that the member still needs to call Magellan for authorization prior to receiving services.**

Other Magellan Resources Online

In addition to the provider directory, members can use self-assessment screening tools for depression (CES-D), alcohol use (Alcohol Use Disorders Identification Test, or AUDIT), or the Social Readjustment Rating Scale, which examines the relationship between major life changes and a person's health.

The enhanced MagellanAssist Web site also provides information on alcohol and drugs, anxiety, children's mental health, depression, eating disorders, medications, post-traumatic stress disorder, schizophrenia, and suicide. It has links to other Web sites for more information on behavioral health topics. The site also includes information on stress reduction, good communication, positive parenting, and other preventive mental health topics.

BlueCross BlueShield of North Carolina

Blue Link Benefit Reminders

Member Responsibility for Lens and Frames Reimbursements

We offer our enrolled employer group accounts an optional Lens and Frames Rider. BCBSNC members must pay for lenses, frames, or contacts–minus any applicable vision discounts–at the time of service. Members then submit a member claim form to BCBSNC for reimbursement of the benefit period maximum for the vision service in question. If you have any questions, please contact your local BCBSNC Network Management field office.

Radiology Modifiers

Here's a quick refresher course in radiology modifiers. "-26" is used to designate the professional component of a procedure. The acceptance of modifier –26 with procedure is based on HCFA RBRVS and the professional RVU is allowed. Modifier "-TC" designates the technical component and will be allowed at a reduced rate in comparison with the allowance for the full service.

Billing for Emergency Room Services

As of January 23, 2003, emergency room services can be billed on a UB-92 outpatient claim with a bill type of 13J whenever the inpatient services are denied for nonauthorized services or certification is not obtained for patients with Blue Care®, Blue Choice®, Blue Options℠, or Classic Blue®, coverage.

Hospital Observation Changes

We notified you in December of changes for 2003 to simplify authorization and claims adjudication regarding the notification process for observation, outpatient surgery, and subsequent inpatient admissions. The following changes were effective March 9, 2003:

- BCBSNC will no longer require notification for hospital observation for Blue Care and Blue Choice plans.
- BCBSNC encourages–but does not require –notification for hospital observation when the patient has discharge needs. This will facilitate the coordination and authorization of discharge services (i.e., home health, home IV therapy, and DME services that do require prior Plan approval for these two plans).
- BCBSNC medical policy for observation has been updated on **bcbsnc.com**.

Please refer to the original letter of December 13th, or contact your Network Management field office for additional information.

BCBSNC Standards of Compliance

In an effort to provide a safe environment for our members to receive quality health care in a timely manner, we have established standards of compliance for medical records, facilities, and access to care against which all primary care practices and OB/GYN practices are measured at least every three years. These standards have been developed with input from our physician advisory groups.

BCBSNC has established the following targets for compliance:

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

Since measurements of these standards began in 1995, we have seen a significant improvement in the results of our biannual reviews. Our network physicians have demonstrated a sincere earnestness to correct any deficiencies noted during the review process. We are pleased to report that the upward trend continued in the 2002 reviews. Of interest is the increase in the availability of translator services, which are now available in 68 percent of primary practices and 73.3 percent of OB/GYN practices.

Medical Records

The 2002 reviews, conducted in 382 practices, resulted in 98.4 percent of the practices meeting or exceeding BCBSNC's standard of 85 percent compliance. Sixty-eight practices (16 percent) were found to be in 100 percent compliance with all standards monitored.

A medical record assessment is also conducted in primary care practices that do not have sufficient patient enrollment to support a complete medical record review. Ninety-four percent of the practices on which medical record assessments were conducted scored 100 percent on the monitored standards. As with medical record review results, there is a deficit in the documentation of smoking/ETOH/and substance abuse counseling and problem lists.

Medical record assessments conducted on high volume practices, such as an OB/GYN practice, resulted in 96.0 percent being in compliance with the monitored standards. The lack of problem lists and prominently posted allergies were the main concerns among this group.

Facility Sites

Overall, 95.1 percent of the primary practices and 96.4 percent of the OB/GYN practices reviewed met the facility standards. Although eleven practices–ten primary and one OB OB/GYN practice– did not have a dedicated emergency kit, this is an improvement from 2001 results. The standard requires that sufficient equipment and supplies be onsite to support life until a patient can be moved to an acute care setting. This means, at a minimum, an ambu bag, airway, and blood pressure cuff. These items should be kept together in a specific place, which is known to everyone on the staff, and ready for "grab and go" in case of emergency. Practices located on hospital campuses are not exempt from this patient safety standard. It was also noted that the availability of toilet facilities equipped for the physically challenged has improved.

Access to Care

The overall compliance rate with the access to care standards among primary care practices was 99.6 percent and 99 percent for OB/GYNs. Time spent in the waiting room for a scheduled appointment was met by 99.6 percent of the primary practices reviewed. Based on analysis of the Provider-Specific Member Satisfaction Survey, time in the waiting room continues to be a source of dissatisfaction to patients. This is perceived as not only the time in the actual waiting room, but also time spent in a second waiting room or an exam room. We would encourage physicians to not only move patients through the waiting room in a timely manner, but also limit the wait time in exam rooms. Additionally, 20 primary practices were found to be open less than the 35 hours per week required in the standards.

Annual Reminder of Facility Standards

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

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

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Access to Care Standards—Focusing on the Patient

Access to care standards have been developed in conjunction with the Provider Advisory Group and Provider Regional Advisory Groups to encourage managed care and PPO network practices to provide timely access to quality health care and services for all members. These standards serve as a basis for practice level monitoring, which is conducted at least every three years. BCBSNC and our Physician Advisory Group have established the following Access to Care Standards for primary care physicians and specialists. **EMERGENT/LIFE-THREATENING CONCERNS SHOULD BE REFERRED DIRECTLY TO THE CLOSEST EMERGENCY DEPARTMENT. IT IS NOT NECESSARY TO SEE THE PATIENT FIRST IN THE OFFICE.**

Waiting Time for Appointments

Urgent health care:
(not life threatening, but a problem needing care within 24 hours)

- **Medical:** Within 24 hours for pediatrics and adults
- **Behavioral Health:** Within six hours for a non-life threatening emergency; within 48 hours for other urgent needs

Symptomatic nonurgent:
Within three calendar days for pediatrics and adults
(example: cold with no fever)

Complete physical examination:
Within 30 calendar days for children
Within 60 calendar days for adults

Regular appointments with a specialist:

- Within two weeks for children and adults with a sub-acute problem requiring a short office visit; within four weeks for adults with a chronic problem requiring a longer visit
- Within 10 business days for behavioral health

Follow-up for urgent care:
Within seven days for pediatrics and adults

Follow-up for chronic conditions:
Within 14 days for pediatrics and adults
(examples: blood pressure check, diabetes checkup)

Time Spent in Waiting Room

(A) Scheduled	After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment. The maximum waiting time is 60 minutes.
(B) Walk - ins	Although walk-ins are discouraged, reasonable efforts should be made to accommodate patients. Life-threatening emergencies must be managed immediately.
(C) Work - ins	After 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling. Maximum waiting time is 90 minutes.

Response Time for Returning Calls After Hours

- **For an urgent need:** 20 minutes
- **For a nonurgent need:** One hour

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

Physician Office Hours

(Indicates hours during which appropriate personnel is available to care for members, i.e., MD, DO, FNP, PA.)

- **Daytime hours for primary care physician:** Seven hours a day, five days a week
- **Night and weekend hours for primary care physician:** Optional, but encouraged
- **Daytime hours for specialists:** Minimum of 15 hours per week covering at least four days a week

Specialist Availability Hours

- **Daytime hours:** 40 hours per week
- **Nights and weekends:** 24-hour coverage

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

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BlueLINK

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Address Correction Requested

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Number One Reason for Claim Mail Backs

Did you know that the number one reason why claims are mailed back is because the provider number is not on the claim form? It's true–leaving off those five digits will result in unnecessary delays for both you and our members.

Blue Cross and Blue Shield of North Carolina (BCBSNC) requires providers to use their five-digit provider number when filing claims. This includes claims filed on behalf of BlueCard® patients. Your BCBSNC provider number must appear in Block 24 K (Performing Provider) and Block 33 with your individual provider number (if applicable) in the "Pin # " field and your group provider number in the "GRP #" field on the HCFA-1500 and in Block 51 on the UB-92 claim form.

Claim filing instructions can be found in *The Blue Book* under the section entitled, "Billing and Claims Submission." To assure timely claims payment and prevent claims from being returned to you, please remember to include your provider number on all claims submissions.