BlueLINK℠

News from Blue Cross and Blue Shield of North Carolina

Fall 2003

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BlueCross BlueShield of North Carolina

Are You Ready for HIPAA?

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

As you are probably aware, Blue Cross and Blue Shield of North Carolina (BCBSNC) has been actively implementing many important decisions that impact the way we do business as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

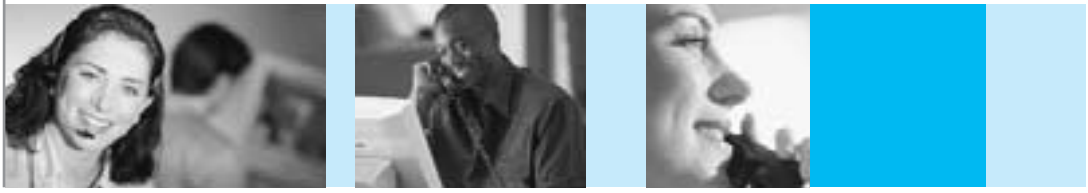
One important change is the way we will process claims in which BCBSNC is both the primary and secondary insurance carrier. For claims processed October 11, 2003, and after, we will no longer automatically forward claims to the member's secondary BCBSNC plan after the claim is processed under the member's primary BCBSNC plan. You will have to submit two separate claims.

Two Claims Now Required for Coordination of Benefits

Submit the first claim to the primary BCBSNC plan using the member's complete ID number (alpha prefix, subscriber number and suffix, if applicable). Upon receipt of the primary Explanation of Payment (EOP), submit another claim to the secondary BCBSNC plan using the member's complete second ID number (alpha prefix, subscriber number and suffix, if applicable) and indicate the primary payment amount from the EOP for electronic claims. For paper claims, submit a copy of the primary payer's EOP with the secondary claim. This is required even when BCBSNC is both primary and secondary.

When BCBSNC is secondary to another insurer or Medicare, remember to include the member's complete BCBSNC ID number when filing the secondary claim to us for consideration. We will also need the primary payment amount from the EOP for electronic claims and a copy of the primary plan's EOP for paper claims.

If our records indicate that BCBSNC is secondary and the primary plan's (including BCBSNC) EOP information is not received, we will deny the claim and request that the primary plan's EOP information (for electronic claims) or a copy of the EOP (for paper claims) be submitted when you file the secondary claim with BCBSNC.



EDI Services: Countdown to HIPAA Compliance

The Health Insurance Portability and Accountability Act (HIPAA) mandates the standardization of EDI formats for health care data transmission, which includes claims, remittance, eligibility and claim status inquiries. HIPAA regulations replace the BCBSNC proprietary electronic HCFA 1500 and UB92 claims formats and the proprietary electronic remittance formats with ASC X12N 837 transactions. BCBSNC and its trading partners of health information are working to be ready for the October 16, 2003, implementation deadline.

BCBSNC has created an EDI Solutions section on our Web site at ***www.bcbsnc.com/providers/edi/***. This section includes helpful information for potential trading partners as they work toward compliance with the HIPAA regulations, including:

- A companion guide to assist trading partners in understanding BCBSNC code and situation handling used in processing the ANSI ASC X12N transactions.
- A Trading Partner Agreement that outlines the obligations of BCBSNC and the trading partner in regard to exchanging standardized data and transactions.
- All Implementation Guide and BCBSNC-specific edits required to create and transmit successful and compliant transactions.
- Electronic Connectivity Request forms, which are required of any provider who sends electronic transactions to BCBSNC, either directly or through a clearinghouse or vendor.
- Production dates on which BCBSNC will be able to accept standardized transactions.
- Testing information for use by potential BCBSNC trading partners in which test files can be sent to BCBSNC and analyzed and evaluated.

Training Available

EDI Services sponsored a series called Differences Trainings in conjunction with the fall Network Management workshops. These workshops focused on the details of HIPAA-compliant transactions and code sets. Health care providers who currently submit electronic claims directly to BCBSNC (i.e., do not use the services of a clearinghouse or third party vendor) are encouraged to access the information presented at these workshops. If you were unable to attend any of these sessions, contact your local EDI Services field consultant to schedule an alternate training session.

Beyond our local Plan, the Blue Cross and Blue Shield Association is developing a system called Blue Exchange for transmitting HIPAA-compliant transactions between Blue Plans. As a provider, you will be able to submit your electronic inquiry (270/271, 276/277, 278) to and receive responses directly from BCBSNC for services conducted on behalf of out-of-area members. All Blue Plans will implement the system by October 16, 2003. BCBSNC will provide the majority of responses to your electronic inquiries using batch and near real-time transactions through **Blue *e***℠. This means that most of your electronic inquiries can be answered within current **Blue *e*** service levels.

The response time to your electronic inquiries for out-of-area members may vary from the response time for local members. This is due to the different approaches Blue Plans are taking to accommodate the real-time and batch response needs of providers from across the country. While electronic transmissions are faster, you may continue to use the existing BlueCard *Eligibility*® number--**1-800-676-BLUE (2583)**--for eligibility and benefits verification for out-of-area members. BCBSNC will continue to provide tips and explain each step of a typical transaction process as well as give examples of what may occur in not-so-typical circumstances. This information is available by contacting EDI Customer Support at **1-888-333-8594** or via email at ***edicussup@bcbsnc.com***.

EDI Services: Countdown to HIPAA Compliance (continued)

Commitment to Compliance

BCBSNC remains committed to maintaining our current level of electronic services to providers. Because of that commitment, we will accept transactions electronically in both HIPAA and current electronic formats prior to and after October 16, 2003. Providers and clearinghouses may receive complaints if they are not ready to send and receive standard transactions. BCBSNC is prepared to assist all trading partners in understanding how to test with us before and after HIPAA implementation in October. HIPAA administrative simplification rules will only be successful if we work together to maintain and surpass our current levels of electronic transactions.

Check the EDI Services Web site at ***www.bcbsnc.com/providers/edi/*** for the most current information regarding HIPAA testing and compliance dates.

Update: BCBSNC Injectable Drug Network

We would like to remind you that our injectable drug network is available to supply you with select injectable drugs for the treatment of your BCBSNC patients*. This network only applies to those injectable drugs that require the supervision of a health care professional. The goals of the program are to help you:

- improve access to and simplify the process of obtaining select injectable drugs.
- streamline the submission of injectable drug claims.
- provide a cost-effective service to you and your patients.

Use of the Network is Voluntary

Our contracted vendors will bill BCBSNC directly for the injectable drug, which results in reducing time and paperwork for your office, as well as removing the financial risk you may have encountered in the past when supplying injectable drugs to patients. Here's a list of the vendors currently participating in the injectable drug network:

VENDOR NAME	TELEPHONE NUMBERS
CareMark	**(800) 571-3922**
McKesson	**(888) 456-7274**
OptionMed	**(800) 720-7522**
NovaFactor (Synagis® only)	**(877) 482-5927**
Priority Healthcare Pharmacy	**(800) 892-9622**
Hemophilia Resources of America (Factor drugs only)	**(336) 854-3128**

We will continue to evaluate the addition of new vendors and drugs to the network. For more information regarding the program, including a list of eligible injectable drugs, please go to the "I'm a Provider" section of our Web Site at ***bcbsnc.com***.

* Please note that Medicare Supplement members are excluded from this program.

Protecting Your Patients' Health Care Needs

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

- any decisions made about coverage for care or service are based on your patient's benefit plan, BCBSNC medical policy and information from the doctor about the patient's medical condition.
- the BCBSNC doctors and nurses who review your or your patient's requests for service or coverage are not rewarded for denying or limiting coverage.

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

Shared Goal: Patient Safety

Since physician prescribing and treatment practices have received a great deal of attention recently, BCBSNC monitors and tracks patient safety-related events. The following initiatives aim to prevent medical errors at the member and physician level:

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

Patient safety interventions such as these can ultimately reduce unnecessary medical expenses and keep our members safe and healthy. For more information about patient safety, email us at ***quality@bcbsnc.com***.

How Are Medical Necessity Decisions Made?

We want to ensure that all physicians are aware of the criteria and guidelines that we use to make medical necessity decisions at Blue Cross and Blue Shield of North Carolina. BCBSNC uses two sets of criteria—the Milliman Care Guidelines and the BCBSNC corporate medical policy. Most of our licensed nurses use Milliman guidelines to authorize coverage for inpatient services and for length-of-stay extensions. They also use the Milliman guidelines for home care and rehabilitation services.

In May of 2003, our Medical Resource Management department implemented the new 8th edition of the Milliman Care Guidelines. These have improved format and updated clinical information. Our corporate medical policy applies more to services that require prior Plan approval. Practitioners can obtain a copy of a specific Milliman Care Guidelines or a BCBSNC medical policy by calling our Medical Resource Management department at **1-800-672-7897, ext. 7078**. Our medical policies are also available online at ***bcbsnc.com*** via the "I'm a Provider" portal.

If a nurse cannot approve a service, a BCBSNC medical director will review the case and may approve or deny coverage based on Milliman Care Guidelines or BCBSNC medical policy, along with clinical judgment. ONLY a medical director can deny coverage for a service based on medical necessity. We encourage you to take part in a "peer to peer" consultation regarding a case before or after a determination, because a discussion between physicians can help clarify a situation and affect the determination. A BCBSNC medical director is always available during regular business hours and can be reached by calling us at **1-800-672-7897, ext. 1019**.

Guidelines for Assistant Surgeons and Physician Assistants

Benefits are allowed for an assistant surgeon's services when medical necessity and appropriateness of services are met. Generally, Medicare guidelines are used to determine this, although cases may be reviewed on an individual consideration basis. Benefits for a covered procedure are 20 percent of the maximum allowed for the procedure. The applicable modifier to use is "- 80."

Benefits are also allowed when medical necessity and appropriateness of assistant surgeon services are met, and when the physician assistant is under the direct supervision of the performing surgeon. The physician assistant must be appropriately certified or licensed in the state where the services are rendered and must be credentialed in the facility where the procedure is performed. The physician assistant benefits for covered procedures are 85 percent of the maximum allowed for an assistant surgeon. The applicable modifier for a surgical assistant is "- AS."

However, it's important to note that a registered nurse, first assistant or nurse practitioner are not eligible for reimbursement as surgical assistants. Please refer to our online medical policies on the topics of co-surgeon, assistant surgeon and physician assistant guidelines for complete details.

Blue Link Time-Saving Reminders

Corrected Claim Filing Tips

We want to be able to process and pay the claims you submit to us as efficiently and quickly as possible. If you're filing a corrected claim, please remember to write "corrected claim" across the top of the revised paper claim form AND complete a Provider Claim Inquiry form. Corrected claims should be mailed to the following address:

BCBSNC
Claims Department
P.O. Box 35
Durham, N.C. 27702-2291

Don't just submit the charge that is being corrected. It is necessary that you submit all charges that were processed on the original claim and Explanation of Payment.

Immunize College Students Against Meningitis

BCBSNC recommends that all college students–particularly those living in dormitories or residence halls–receive the meningococcal polysaccharide vaccine this fall. We will provide coverage for the vaccine when a participating provider administers it. If you are unable to administer the vaccine, please refer BCBSNC patients to another participating provider that does administer it.

If the patient needs to go out-of-network to receive the vaccine, please contact our Medical Resource Management department at **1-800-672-7897**. The patient will need authorization prior to receiving the vaccine out-of-network or the claim will deny.

Have You Updated Your Address With Us Lately?

Our returned mail has been overwhelming. Several reasons contribute to the problem: out-of-date address information, providers or office managers no longer with a practice, etc. Please help us update our provider addresses and contact information. Please contact your local BCBSNC Network Management representative and verify that we have your current practice name, address, email address and BCBSNC provider number on file.

Verify Patient ID Number at Each Visit

Please remember to request a copy of your patients' ID card and confirm their coordination of benefits information at each visit. As a result of HIPAA, we will no longer try to correct incomplete or erroneous information in order to process claims. Submitting claims with the correct and complete member ID number (alpha prefix, subscriber number, suffix if applicable) is imperative to preventing claims from being returned to you for corrections and resubmission.

Only National Codes Now Accepted

We now only accept active codes from national code set sources such as ICD-9, CPT and HCPCs. As new codes are released, please convert to them by their effective date in order to prevent claims from being mailed back for recoding and resubmission. Deleted codes will not be accepted for dates of service after the date the code becomes obsolete.

Emergency Room Services

Charges for an ER visit that does not result in an approved admission must be submitted separately for consideration of payment using a bill type of 13J on the UB-92 form in form locator 4. 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.

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.

Alpha Prefix Guide

P F A Rx

FEP – "R" alpha prefix – 1-800-222-4739

State – No alpha prefix – 1-800-422-4658

BlueCard® – If the alpha prefix is other than YP or PEQ, call 1-800-487-5522 for claims information and 1-800-676-2583 for eligibility/benefits.

Legacy (Claims & Eligibility)
Call 1-800-214-4844

- Preferred Care® CostWise®[1] (YPA)
- Blue Advantage® (YPB)
- Preferred Care® *Select* (YPN) (YPB)
- Med*Point*SM[1] (YPA)
- Personal Care PlanSM[1](YPL)
- Medicare Supplemental (YPZ - effective 07/01/03)

New Blue (Claims & Eligibility)
Call 1-877-258-3334

- Blue Options℠ (YPP) (YPE) (PEQ)
- Blue Advantage® (YPP – effective 04/01/04)
- Classic Blue® (YPM)
- Blue Choice® (YPS) (YPG)
- Blue Care® (YPH)

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*Innovative health care designed around you.*SM[1] | bcbsnc.com

Information on Managing Migraine Headache Sufferers

Migraine is not “just a headache.” Migraine is a common, neurobiological disorder that afflicts approximately 28 million Americans – 13 percent of the population. Migraine costs American employers about $13 billion per year in missed work and reduced productivity. Fifty-one percent of people with migraine have reported at least one day where productivity at work or school was reduced by at least 50 percent.

Many people with migraine have the mistaken belief that they have sinus headache or stress/tension headache. Over 50 percent of migraine sufferers are undiagnosed or inaccurately diagnosed. Additionally, many migraine sufferers continue on outdated treatment approaches that have limited efficacy for migraine or troublesome side effects, or they overuse narcotics and other pain-killing drugs that may lead to dependency, addiction or rebound headache. Consequently, migraine sufferers have a higher tendency for poor clinical outcomes, dissatisfaction with care and a higher than necessary cost of care.

Managing Migraine Tools Available

Upon request, BCBSNC offers physicians informational packets on the “Standards of Care for Headache Diagnosis and Treatment” as established by the National Headache Foundation. We can also provide you with migraine clinical care pocket cards and tip sheets on the biology of migraine, use of diagnostic technology, optimizing pharmacotherapy, rebound headache and a migraine patient counseling guide.

For your BCBSNC patients, we offer a migraine headache program designed to support the diagnosis and appropriate management as part of the *Your Healthy Best*® health management program. BCBSNC members who suffer from migraine headaches will receive comprehensive educational materials, a headache diary and personalized support from registered nurses to help complement the care they currently receive from you, their physician.

For more information on the migraine care initiative as part of the *Your Healthy Best* program, or if you would like to request a physician information package, please call us at **1-800-218-5295, ext. 1303**. You can also refer a patient to the program via our Web site at ***bcbsnc.com***.

Specialty Services Available for Patients With Chronic Conditions

Do you have patients who have ALS, cystic fibrosis, dermatomyositis, CIDP, Gaucher's disease, hemophilia (A&B), multiple sclerosis, myasthenia gravis, Parkinson's disease, polymyositis, rheumatoid arthritis, sickle cell anemia, systemic lupus erythematosus, or scleroderma? If so, they may be eligible to participate in Blue Cross and Blue Shield of North Carolina's free and confidential *Your Healthy Best®-Specialty Services* program. This program can really make a difference for your patients. Here are just a few of the impressive program results to date:

- A 42 percent reduction in ER visits among participants who have multiple sclerosis[1].
- A 21 percent reduction in the percent of rheumatoid arthritis participants who report having problems with pain in the last three months[1].
- 100 percent satisfaction with the program, with comments such as "I appreciate the brochures and phone calls." "They are very caring…" "I am a retired nurse…and am not familiar with my condition." "Your services have been very helpful to me"[2].

Participants in the *Your Healthy Best-Specialty Services* program receive comprehensive educational materials and personalized support from specially trained registered nurses. Participants also have Web site access to disease-specific information and services, chat rooms, frequently asked questions and library services. To learn more about this program or to refer a BCBSNC patient to the program, please call us at **1-800-218-5295**.

[1] Change between the quarter prior to enrollment in the program and the fourth quarter they were enrolled in the program; Accordant Q12003 report
[2] 2002 Accordant Satisfaction Survey

Federal Employee Program: Claims Submission Tips

Professional Claim Filing Tips

When filing a professional claim for services due to an accidental injury, please remember to include the date of the accident/injury in Block 10 of the HCFA 1500 claim form.

When duplicate procedures, such as tissue exam 88305, are performed multiple times on the same date, please remember to submit all procedures on one line and indicate the number of units. Correct filing of this type of service will prevent a denial of duplicate services on the same day.

Facility Claim Filing Tips

When a patient is transferred from one unit to another (i.e., from surgical unit to rehab), then all charges should be billed inclusively AFTER the patient has been discharged.

Maternity charges for mother and newborn should be submitted at the same time, but the actual charges for the mother's care should be shown separately from the charges for the newborn.



Sponsor a Team for the American Heart Walk

As you know, cardiovascular disease (CVD) is the leading cause of death in North Carolina. North Carolina's CVD mortality rate is the 14th highest in the U.S. Approximately 170,000 hospitalizations each year are due to CVD, which account for an estimated $2 billion in hospital charges. North Carolina currently ranks among the five worst states in the nation with respect to adult tobacco use and sedentary lifestyle--both important risk factors for CVD. National statistics for CVD are even more staggering at over $200 billion spent on health care and over $140 billion in estimated lost productivity.

You can make an impact on the health of your community by sponsoring a team of walkers at the 2003 American Heart Association Walk. The mission of the American Heart Association is to reduce disability and death from cardiovascular diseases and stroke. It's a great way for your employees, friends and/or relatives to get some exercise, have some fun and learn how to be heart healthy!

EVENT NAME	LOCATION	DATE	CONTACT
2003 American Heart Walk-Fayetteville, North Carolina	Fayetteville	October 4, 2003	Jennifer Hawley (910) 323-9387
2003 American Heart and Stroke Walk at Tanglewood	Clemmons	October 18, 2003	Cindy Logan (336) 668-0167
2003 American Heart Walk - Wilmington	Wrightsville Beach	October 18, 2003	Kelly Ballance (910) 392-5433
2003 American Heart Walk-Rocky Mount/Nash/Edgecombe	Rocky Mount	November 1, 2003	Kim Etheredge (252) 355-1112
2003 American Heart Walk – Raleigh/Durham/Chapel Hill	Research Triangle Park	November 2, 2003	Kim Raynor (919) 463-8300
2003 American Heart Walk – Eastern North Carolina	Greenville	November 15, 2003	Kim Etheredge or Nichelle Murry (252) 355-1112
2004 American Heart Walk - Wilson, NC	Wilson	April 24, 2004	Kim Etheredge (252) 355-1112

Credentialing Made Easier

Blue Cross and Blue Shield of North Carolina (BCBSNC), working with the Council for Affordable Quality Healthcare (CAQH), is committed to streamlining the administrative process for physicians and other health care providers. BCBSNC has been an active participant in CAQH's efforts to develop a secure, online database that helps eliminate the need for physicians and other health care providers to fill out and submit multiple credentialing/recredentialing applications. Initially, this new system is available to M.D's, D.O.'s, chiropractors, podiatrists and dentists. We will notify additional disciplines of their eligibility to use the system as it becomes available in the future.

Data Source Alleviates Administrative Requirements

The innovative credentialing system works this way–each physician or health care provider will submit just one standard application to a single database that is designed to meet the informational needs of participating health plans. Benefits include:

- Easy online or fax submission of information.
- Providers can easily update their information anytime and will be asked quarterly to verify the accuracy of the information on file. In addition, there is a system in place to automatically notify health plans when the health care provider's information is updated.
- Participating health plans can access the credentialing information anytime as long as the provider has authorized it.
- Health plans can continue to conduct data verification and review and can make an independent decision about whether a provider meets that insurer's standards for participation.

There is no cost for physicians and other health care providers to submit information to the credentialing data collection system. The costs associated with developing and maintaining the system are paid by the participating CAQH health plans. Health care providers in Virginia and Colorado were the first to implement the system, and other states have been joining since last summer.

In developing the system, CAQH worked closely with health plans, providers, professional associations and accreditation organizations to help make the system meet the needs of all involved in the credentialing process. CAQH selected GeoAccess, a leader in health care data management, as its technology partner. GeoAccess will collect, maintain and secure all data in its state-of-the-art data center.

To learn more about CAQH and the new CAQH Universal Credentialing DataSource, please visit their Web site at ***CAQH.org***, where you can view an online demonstration of the system.

Hepatitis C – A Quiet Disease

Did you know that more than four million people in the U.S. have hepatitis C, which is the leading cause of liver transplants? A small percentage of people who contract the disease will clear the infection spontaneously. But 80 percent will develop a chronic infection and about 20 percent of these people will eventually develop cirrhosis of the liver if the condition is left untreated.

Who is At Risk?

The following factors can put a person at risk:

High Risk Factors

- Elevated liver enzymes
- Blood transfusions prior to 1992
- Organ transplants prior to 1992
- Blood-clotting factor received before 1987
- HIV infection
- Hemodialysis
- Shared needles and other equipment used to take illegal drugs (even if it was only experimental)

Lower Risk Factors

- Tattoos or piercing with unsterilized equipment
- Multiple sex partners
- Users of inhaled cocaine

Hepatitis C is called a quiet disease because there are few symptoms. If symptoms do occur, they are often mistakenly attributed to other conditions. Common symptoms include: fatigue, loss of appetite, fever, joint pain, nausea, dark urine, clay-colored stool or jaundice. If cirrhosis has occurred, symptoms such as broken blood vessels on the chest and shoulder, fluid retention in the abdomen or redness in the palms of a patient's hands will be apparent.

Suggested Treatment Protocol

Patient determined to be at risk (based on the above risk factors and symptoms)

→ Abnormal ALT (elevated ALT with minimally abnormal to normal levels of alkaline phosphatase and bilirubin)

↓ Positive anti-HCV

↓ Consider referring patient to a BCBSNC participating physician specializing in the treatment of hepatitis C or to one of the following university hospitals located in North Carolina. These hospitals are part of BCBSNC's network of participating providers.

University Hospital Programs

PROVIDER	LOCATION	CONTACT NUMBER
Duke Liver Services	Durham, N.C.	919-681-6819
ECU Brody School of Medicine Division of Gastroenterology and Hepatology	Greenville, N.C.	252-744-4652
UNC Liver Program	Chapel Hill, N.C.	919-966-2516 or ***hopeforhepc.com***

Hepatitis C – A Quiet Disease (continued)

Treatment Guidelines

Treatment for hepatitis C has come a long way in the past several years – and the good news is that many people with hepatitis C can be cured. In fact, according to Michael Fried, M.D., director of Clinical Hepatology at UNC Hospitals, "with the newest medications, over 50 percent of patients with chronic hepatitis C can be cured. For the first time with any chronic viral infection, the chance of treatment success is greater than the chance of failure."

Studies have shown that taking combination therapy of artificial interferons (Peginterferon) in combination with an antiviral drug (Ribavirin) can cure hepatitis C in many patients. Studies have also identified which patients are not likely to respond to therapy. If a patient does respond to treatment, then the duration of therapy will depend upon the genotype. Genotype 1 standard of care is 48 weeks and Genotype 2 and 3 standard of care is 24 weeks.

As with any drug treatment, the key to success is compliance. Being compliant can be a particular challenge for patients with hepatitis C, because there are substantial side effects to the therapy (such as flu-like symptoms, depression and suicidal tendencies) that require management by a health care professional. Managing hepatitis C patients can be particularly challenging for physicians, and according to Dr. Fried, "hepatitis C has an impact on the individual in ways that go beyond the liver disease. When managing patients with chronic hepatitis C, it's important to focus on the individual while also concentrating on their liver disease."

Patient Education Is Key

Patients should also be advised to take additional steps to reduce long-term damage (regardless of whether they are on drug treatment):

- Eliminate alcohol from their diet – alcohol can significantly increase the progression of liver damage.
- Eliminate tobacco use.
- Avoid herbal supplements without discussing first with a health care professional.
- Eat a healthy diet and get regular exercise.

Not all patients are eligible for treatment. Patients with decompensated liver disease, coronary artery disease, uncontrolled diabetes or chronic obstructive pulmonary diseases may not be eligible for treatment. Female patients need to be advised that pregnancy must be delayed for at least six months following the end of therapy.

Resources Available for Your Hep-C Patients

It is important that patients have access to accurate information regarding hepatitis C, so they can better understand their condition and what lifestyle changes need to be made. Schering-Plough and Roche both offer support and education via Web sites and nurse call lines to patients on their drug regimens:

- *Be In Charge* – offered by Schering-Plough. For more information, patients can visit **beincharge.com** or call **1-888-HEP-2608 (437-2608)**.
- *Pegassist* – offered by Roche. For more information visit, patients can visit **pegasys.com** or call **1-877-PEGASYS (1-877-734-2797)**.

BCBSNC members can talk to a nurse any time day or night by calling our 24-hour health information line, Health Line Blue℠ at **1-877-477-2424**. Members can also log onto Health Line Blue's Dialog Center on **bcbsnc.com** and track their symptoms and medications, as well as search the Healthwise® Knowledge base for more information on hepatitis C.

Medication Safety Program for Patients Taking Multiple Prescriptions

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

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

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

Informing and Empowering Members

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

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

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

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

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

For more information about the Medication Safety Program, or to see a copy of the brochure, please visit our Web site at **bcbsnc.com**. Just click on the "Find a Drug" button in the top right corner of our home page, and select "Medication Safety Program" from the menu under "Pharmacy Services." If you have any questions about this program, please contact Denis O'Connell M.D., regional medical director for BCBSNC and co-chair of the BCBSNC Pharmacy & Therapeutics Committee at **1-800-446-8053** or **919-765-1368**.

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New Rx Dosage = New Prescription

Prescribing physicians often tell patients to increase their dosage of chronic medications, but for various reasons do not write a new prescription with the new directions and/or revised quantity of the drug in question. This puts both the patient and the pharmacist in an awkward situation, as the pharmacist may receive a "refill too soon" rejection message from the PAID System when the patient requests a refill.

The pharmacist can take the following steps to assist the patient:

- If possible, have the patient explain why the physician recommended a new dosage.
- Contact the prescribing physician to confirm the new dosage and/or quantity of the medication.

  TIP: ***If the medication is available in an appropriate higher-dose tablet, recommend this option to the patient. Using one higher-dose tablet instead of several equivalent, lower-dose tablets will help to ensure patient compliance and may be more cost-effective for the patient too.***
- Call the prescribing physician and generate a new prescription with the appropriate refill amount after receiving confirmation from the doctor.
- Resubmit the claim.

How to Override in Emergency Situations

If the patient needs medication right away and the physician cannot be contacted immediately, the pharmacist can use the following override process:

- Enter "05" in the Prescription Denial Clarification field, which reads "daily dosage, therapy changed by prescriber."
- Resubmit the claim.
- Document the reason for the override on the original hard copy prescription.
- Remind the patient that they will need to get a new prescription from their doctor for the next refill.

Use the "03" override code in situations when members are going on vacation or will be out-of- town for an extended period and need early refills for that reason. The override process is outlined in section 2.6 of the *Pharmacy Services Manual*. If you have any additional questions, please call the PAID Pharmacy Services Help Desk at **1-800-922-1557**.

New Clinical Formulary in the Mail

The Blue Cross and Blue Shield of North Carolina (BCBSNC) formulary is designed to assist you in maintaining quality of care for patients while helping to minimize their out-of-pocket expenses. Updated formularies will be mailed out in September.

The formulary provides information regarding 2-Tier and 3-Tier benefit plans. Please check your patient's BCBSNC ID card to see if they participate in a drug coverage program that utilizes a tier-based formulary. By prescribing generic medications for your patients–when clinically appropriate–you will help limit the cost of drugs for your patients.

For members enrolled in 3-Tier benefit plans, you can also help limit their drug costs by prescribing preferred brands, which are Tier-2 drugs. For members participating in our HMO products, some drugs may require prior approval or may be subject to quantity limitations. Drugs subject to either will be indicated as such in the formulary. Additional information, including an online version of the formulary, can be found on our Web site at ***bcbsnc.com***.

Change to State Health Plan Retrospective Prior Approval Policy

Effective January 2, 2004, the State Health Plan is making a change to its retrospective prior approval policy. In order for a claim to be considered for retrospective review, requests must be received within six months (180 days) of the end date of service. Requests received after 180 days of the end date of service will be denied even if the services were provided in the appropriate setting and met medical necessity criteria as defined by the State Health Plan.

State Health Plan: Facility Ambulance Claims

Prior to April 22, 2003, when facilities filed an ambulance service on a UB-92, only the mileage was required. After that date, the State Health Plan now requires that ALL ambulance claims be filed with the HCPCS code and appropriate modifier. Air ambulance and licensed land-ambulance service over 50 miles will require prior approval. Claims that are submitted without the HCPCS code and modifier will be mailed back to the facility for correction.

Admit and Discharge Dates for State Health Plan Members

The admit and discharge dates are required for all inpatient claims, including professional claims. Due to the new HIPAA mandates, the State Health Plan is mailing back inpatient professional claims that do not have the admit and discharge dates included. Also, any claims received with incomplete or missing information will be mailed back to the provider for completion. This is not a new process, just one that is now being enforced appropriately.

Recent State Health Plan Appeals Decisions

At the most recent State Health Plan Board of Trustees meeting, several appeals were reviewed on behalf of State Health Plan members. For the most part, the resulting decisions were based on existing benefits or exclusions, so we thought you might find it helpful to see a summary of some of the appeals, as well as a reminder about the State Health Plan benefits in question.

Out-of-State Hospital Reimbursement: The State Health Plan pays inpatient hospital medical claims based on Diagnosis Related Groupings (DRG). Reimbursement is based on either the DRG allowance or actual billed charges–whichever is less. In a case where the charge for the hospital stay is higher than the DRG allowance, the member is responsible for the difference between the actual charge and the allowed amount.

Echosclerotherapy for Varicose Vein Treatment is considered to be investigational and is not covered.

Medication and Use of a Device to Deliver Medication Subcutaneously must have market approval from the U.S. Food and Drug Administration for the purpose being requested. If not, it is considered experimental.

Radial Keratomy, Lasik Eye Surgery, or Other Procedures to correct vision in lieu of corrective lenses is excluded from benefits under the State Health Plan.

Enteral Formula and Other Nutritional Supplements are not covered by the State Health Plan.

Professional Charges for Dental Procedures Not Related to Accidental Injury: Benefits are limited to dental surgery and appliances for mouth, jaw and tooth restoration necessitated because of external violent or accidental means.

Additional Private Duty Nursing: The allowance for private duty nursing shall not exceed the State Health Plan's usual, customary, and reasonable allowances, or 90 percent of the daily semi-private rate, at skilled nursing facilities as determined by the State Health Plan.

State Health Plan: Coordination of Benefits

When the State Health Plan is the secondary insurance carrier, coordination of benefits (COB) applies to all inpatient and outpatient claims. The State Health Plan includes a COB provision so that total payments from both plans do not exceed 100 percent of the State Health Plan allowance. This means that the State Health Plan coordinates benefits up to its allowance and not the total charge.

When a patient has both State Health Plan and BCBSNC coverage, you must first file a claim directly to the primary carrier. Upon receipt of the primary carrier's payment, submit the claim along with the primary carrier's Explanation of Benefits (EOB) to the secondary carrier. Claims received without the EOB will be denied.

Are You Using the Correct Address for State Health Plan Claims?

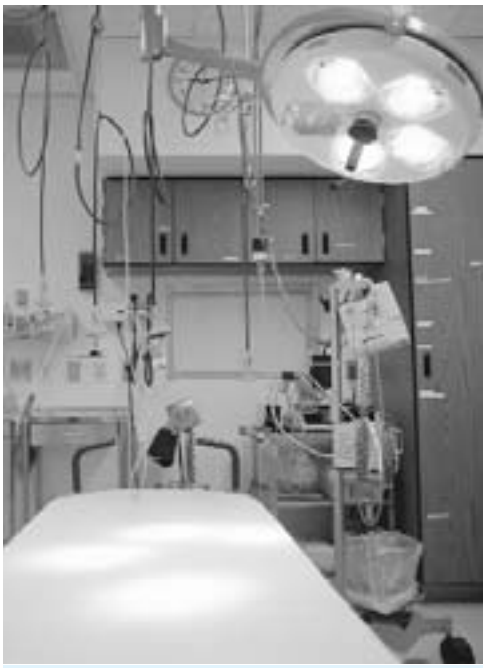
We continue to receive a large volume of claims for regular BCBSNC business that are mailed in error to the State Health Plan claims address. If a patient's ID number has an alpha prefix, the claim should be mailed to BCBSNC at P.O. Box 35, Durham, N.C. 27702. ***(Please note that State Health Plan ID numbers do not have alpha prefixes.)*** Claims and correspondence sent to the incorrect address will be mailed back. When contacting the State Health Plan, please use the addresses listed below:

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

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

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

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



How to Check Status of Inpatient Hospital Claims for State Health Plan Patients

State Customer Service has noticed an increase in calls from hospital personnel requesting that we pull claims for which there is no status, and re-key them using the Document Control Number (DCN). We are unable to comply with this request and we would like to explain why.

When an electronic claim is transmitted to Blue Cross and Blue Shield of North Carolina, it is assigned a DCN number if it is essentially "clean" and passes all front-end edits. This number is also your proof that a "clean" claim has been filed. However, at this point, the claim has not been subjected to room accommodation rate validation. Once the claim is routed to the appropriate line of business, the room accommodation rate is checked; and if correct, the claim is loaded on the system for benefit determination.

On the other hand, if a claim is filed with the incorrect room accommodation rate, the claim is deleted and mailed back to the facility for correction. When this happens, our ability to view the claim is lost. If you call State Customer Service and ask them to pull an image of the claim and have it re-keyed using the DCN number, the outcome will be the same—deletion and mail back of the claim. There are certainly other reasons why a claim may be deleted and mailed back, but invalid room accommodation rate is the number one reason.

How We Can Work Together

While we understand that BCBSNC regular business employs a different procedure concerning DCN numbers, it's important to note that the State Health Plan does not follow the same procedure, as we do not have access to the same information. We have developed a procedure that State Customer Service can use when asked to pull an image of a claim using the DCN number. If you call us and give us a DCN number, you will be asked to do the following:

- Check your Statement of Accommodation (SOA) and verify that the revenue code and accommodation rate entered on the claim matches the contractual SOA.
- Verify that the bill type is accurate as billed.
- Make the corrections and refile the claim electronically.
- Check **Blue *e***℠ for status or contact State Customer Service during the next two to three business days. At that time, there would be a record of the claim showing it as either paid, denied or pending.
- If the claim makes it through all the edits and still gets "hung up" in the system, State Customer Service should be able to locate the claim and tell you what is wrong with it or get assistance in having the claim released. Please note that if a claim suspends, it will only remain in the system for two to three days before it is deleted and mailed back.



New Blue Options℠ Plans Available

In an effort to continue offering products to meet the needs of the changing health care market in North Carolina, BCBSNC is introducing two new plan designs under our Blue Options product. The first option is an all deductible and coinsurance plan. Under this plan, all services (including office visits, urgent care, emergency room services) are subject to both the deductible and coinsurance.

The second new Blue Options plan is an in-network-only design. For services to be covered, they must be rendered in-network with the exception of emergency room services and urgent care. The benefits for all Blue Options PPO plans—"copay", "deductible and coinsurance only", or "in-network only" – will be clearly stated on the member's BCBSNC ID card. A box in the upper right hand corner that states "No Out-of-Network Benefits" will distinguish the in-network-only Blue Options design. The table below compares the two new plan designs to the standard Blue Options design:

PLAN DESIGN	OFFICE VISIT		PRESCRIPTION DRUG		HOSPITAL STAY		EMERGENCY ROOM	
	IN-NETWORK	OUT- OF-NETWORK	IN-NETWORK	OUT- OF-NETWORK	IN-NETWORK	OUT- OF-NETWORK	IN-NETWORK	OUT- OF-NETWORK
BLUE OPTIONS (standard)	Copay	Coinsurance	Copay or Coinsurance (depends on plan design and whether drug is generic or brand)	Copay or Coinsurance (depends on plan design and whether drug is generic or brand)	Deductible and Coinsurance	Deductible and Coinsurance	Copay	Copay
BLUE OPTIONS (deductible and coinsurance only)	Deductible and Coinsurance	Deductible and Coinsurance	Copay or Coinsurance (depends on plan design and whether drug is generic or brand)	Copay or Coinsurance (depends on plan design and whether drug is generic or brand)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
BLUE OPTIONS (in-network only)	Copay	No Benefits	Copay or Coinsurance (depends on plan design and whether drug is generic or brand)	No Benefits	Deductible and Coinsurance	No Benefits	Copay	Copay

New DME Fees Based on Medicare Pricing

Effective August 1, we began using a new durable medical equipment (DME) fee schedule based on Medicare pricing and fee schedule categories. The following table summarizes this reimbursement methodology. You can access more information about Medicare pricing at ***palmettogba.com***.

Codes without Medicare pricing will be reimbursed at the contract percentage of the approved charge, which is based on the St. Anthony Publishing/Medicode North Carolina adjusted reimbursement methodology (see ***IngenixOnLine.com***). If this is not available, the code will be given individual consideration based on factory invoice and medical necessity documentation submitted with the claim.

RENTAL	PURCHASE	CATEGORY	DESCRIPTION	RENTAL PRICING BASE*	PURCHASE PRICING BASE*
X	X	1	Inexpensive or other routinely purchased DME, TENS	Medicare price if applicable	Medicare price
X	X	2	Items requiring frequent and substantial servicing	Medicare price	N/A
X	X	3	Prosthetic and orthotic devices	N/A	Medicare price
X	X	4	Capped rental items	Medicare price	Rental price x 15, use NU or UE
X	X	5	Oxygen and oxygen equipment	Medicare price if applicable	Medicare price if applicable (currently seven supplies can be purchased)
X	X	6	Customized items	Individual consideration (IC)	Individual consideration (IC)
	X		Ostomy, supply, surgical dressing	N/A	Medicare price

* Contract percentages are applied to the base price.

Rental/Purchase Modifers

NU - New equipment
UE - Used equipment
RR - Rental

Maintenance/Repair Modifiers (applicable to purchased items, including Category 4 and Capped Rental Items)

MS - Maintenance and service
RP - Replacement and repair

The Importance of Preventive Care Counseling for Men

Men are notorious for avoiding a visit to their doctor, even when they have an injury or illness. Men see a physician about 30 percent less than women do, and men are more likely than women to suffer severe chronic conditions or fatal diseases and to suffer from them at an earlier age[1]. Ultimately, the life expectancy for men is six years less than women. One of the reasons that men have a higher mortality rate is the length of time they wait before seeing a doctor and receiving treatment for illness.

Because of most men's reluctance to see their physician for routine preventive care, every practice encounter with a male patient is an important opportunity for preventive care, including assessment, education and intervention[2]. A preventive health approach to patient care based on risk analysis and targeted preventive services is endorsed by major medical organizations, including the American Medical Association, the American College of Physicians, and the U.S. Preventive Services Task Force.

Please take this opportunity to discuss preventive health with your male patients whenever they are in your practice. A preventive health discussion should address the patient's health screening needs such as a complete physical, blood pressure and cholesterol check, as well as lifestyle issues such as smoking, alcohol and/or drug abuse, obesity, nutrition, and fitness. For men over 50, include a discussion about colorectal cancer screening and prostate cancer. Even a brief reminder that a patient needs to quit smoking, get more exercise, or get their preventive health screenings can leave a lasting effect on their health consciousness.

[1] Centers for Disease Control and Prevention, *www.cdc.gov/nchs/fastats*

[2] Courtenay, William H. "Behavioral Factors Associated With Disease, Injury, and Death Among Men: Evidence and Implication for Prevention." *The Journal of Men's Studies*, 9:1. Fall 2000. 81-142.

New Clinical Practice Guideline: Attention Deficit/Hyperactivity Disorder

According to the American Academy of Pediatrics (AAP), attention-deficit/hyperactivity disorder (AD/HD) is the most common neurobehavioral disorder of childhood. It is one of the most prevalent chronic health conditions affecting school-aged children. In recent years, increasing attention has been paid to this condition, in part because there is concern that AD/HD might be either under- or overdiagnosed – or both.

A study by pharmacy benefits manager Express Scripts in the February 2003 issue of *Pediatrics* found that North Carolina had the second highest percentage of school-aged children with commercial health insurance benefits who were taking drugs to treat AD/HD. North Carolina's rate was 5.6 percent, second only to Louisiana at 6.5 percent. The average rate was 4.3 percent. Given that the AAP estimates the prevalence of AD/HD among school-aged children to be between 4 percent and 12 percent, it is unclear whether North Carolina's rate is too high, too low or on target.

Increasing Awareness

In the interest of increasing awareness and helping provide information on the diagnosis and treatment of this condition, Blue Cross and Blue Shield of North Carolina is sharing a newly approved clinical practice guideline for AD/HD.

The guideline was developed by Dr. James Byassee, Ph.D., a clinical psychologist practicing in the Durham area. It underwent clinical review by the BCBSNC-Magellan Behavioral Health Quality Improvement Committee as well as the BCBSNC Provider Advisory Group. It draws upon diagnostic criteria from the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fourth Edition – Text Revision* as well as AAP clinical practice guidelines on the diagnosis and treatment of AD/HD. Both medication and nonpharmacologic interventions are discussed.

We would like to share with you the following summary of the guideline, "ADHD Across the Life Span: A Summary for Primary Care Physicians." We hope this tool will be helpful to your practice.

The full text of the guideline is available upon request. If you would like a copy of the full monograph, please call us at **1-800-811-8324** or email us at ***quality@bcbsnc.com***. We also plan to publish the full text on our Web site in the near future.

ADHD ACROSS THE LIFE SPAN:

A Summary for Primary Care Physicians

CLINICAL PRACTICE GUIDELINES: ATTENTION DEFICIT/HYPERACTIVITY DISORDER*

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (DSM-IV-TR)

A. Must have either (1) or (2); and B, C, D, & E:

(1) Six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with development level:

Inattention

_____ (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
_____ (b) often has difficulty sustaining attention in tasks or play activities
_____ (c) often does not seem to listen when spoken to directly
_____ (d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
_____ (e) often has difficulty organizing tasks and activities
_____ (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
_____ (g) often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books, or tools)
_____ (h) is often easily distracted by extraneous stimuli
_____ (i) is often forgetful in daily activities

(2) Six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with development level:

Hyperactivity

_____ (a) often fidgets with hands or feet or squirms in seat
_____ (b) often leaves seat in classroom or in other situations in which remaining seated is expected
_____ (c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness.)
_____ (d) often has difficulty playing or engaging in leisure activities quietly
_____ (e) is often "on the go" or often acts as if "driven by a motor"
_____ (f) often talks excessively

Impulsivity

_____ (g) often blurts out answers before questions have been completed
_____ (h) often has difficulty awaiting turn
_____ (i) often interrupts or intrudes on others (e.g. butts into conversations or games)

_____ B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

_____ C. Some impairment from the symptoms is present in two or more settings (e.g. at school [or work] and at home).

_____ D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

_____ E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

*** May require formal mental health evaluation ***

_____ 314. 01 **Attention-Deficit/Hyperactivity Disorder, Combined Type**: If both Criteria A1and A2 are met for the past 6 months.

_____ 314.00 **Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type**: if Criterion A1 is met but not Criterion A2 for the past 6 moths.

_____ 314.01 **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type**: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

_____ 314.9 **Attention-Deficit/Hyperactivity Disorder, not otherwise specified**: For subsyndromal cases that do involve significant impairment.

AMERICAN ACADEMY OF PEDIATRICS' ADHD PRACTICE GUIDELINES (2000, 2001).*

Routine health examinations may assist in early recognition of ADHD, and primary care clinicians should initiate an evaluation for ADHD in children who present inattention, hyperactivity, impulsivity, academic underachievement or behavior problems.

The diagnosis of ADHD requires that a child meet *DSM-IV* criteria; diagnostic tests are not routinely indicated to establish the diagnosis of ADHD.

The assessment of ADHD requires evidence directly obtained from parents or caregivers regarding the core symptoms of ADHD (inattention, impulsivity, hyperactivity) in various settings, the age of onset, duration of symptoms, and degree of functional impairment.

Evidence directly obtained from other settings, such as the classroom teacher (or other school professional) regarding the core symptoms of ADHD, duration of symptoms, degree of functional impairment, and associated conditions should also be a part of the assessment.

Evaluation of the child with ADHD should include assessment for the commonly found associated (coexisting) conditions.

Epidemiologic studies reveal prevalence rates generally ranging from 4%to 12% in the general population of 6 to 12 year olds and similar or slightly lower rates of ADHD exist in pediatric primary care settings.

Physicians should educate the family and child about ADHD as a chronic condition, serve as a source of information, provide resources, and coordinate health and other services as indicated. Development of child-specific treatment plans and goals, including plans for follow-up, are essential.

The core symptoms of ADHD (inattention, impulsivity, hyperactivity) can create impairment in many areas (home, school, community), and the main focus of treatment should be to maximize function. Realistic and measurable outcomes should be established such as improvements in relationships, self-esteem, and school performance, and a decrease is disruptive behaviors.

Psychostimulant medications comprise the first-line treatment. Second-line treatment includes antidepressants such as tricyclic antidepressants (imipramine, desipramine) and bupropion. Physicians are advised to titrate upward from an initial low dose for better response. If side effects and/or no further improvement in response occur, titrating downward should be considered, with the aim being to find the dose that achieves the highest efficacy with minimal side effects.

If one psychostimulant does not work at the highest feasible dose, the physician should recommend another. Most ADHD children who do not respond to one stimulant will respond to an alternate one. A lack of response is an indication that the accuracy of the diagnosis should be reviewed and/or an additional evaluation for a coexisting comorbidity should be performed.

As a separate treatment modality or as an adjunct to medication, behavior therapy has proved to be a successful interventionówhile it is implemented and maintained. The goal is to adjust the physical and social environments to change behavior, using one or more of the following techniques: positive reinforcement, time-out, response cost, or token economy. Parents or caretakers receive training in the various modalities and in conjunction with teachers, usually implement behavior therapy.

Both parent- and teacher-completed rating scales that specifically assess symptoms of ADHD in the diagnostic process have significant diagnostic and treatment follow-up utility.

When the selected management for a child with ADHD has not met target outcomes, physicians should evaluate the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of coexisting conditions. A lack of response to treatment may be the result of unrealistic target symptoms, incorrect diagnosis, lack of information about the child's behavior, not adhering to the therapeutic regimen, the presence of a coexisting condition, or treatment failure. True treatment failure includes lack of response to two or three stimulant medications and/or behavior therapy, and the existence of a coexisting condition.

The physician should periodically provide a systematic follow-up for the child with ADHD. Monitoring should be directed to target outcomes and adverse effects by obtaining specific information from parents, teachers, and the child. Follow-up office visits and continued communication with others involved (e.g., teachers, counselors) should be maintained. Behavior report cards and checklists are examples of two methods of obtaining ongoing information.

ADHD is now recognized as a life span disorder with similar treatment needs for ADHD adolescents and adults.

* See below

ADHD TREATMENT & PRACTICE GUIDELINES

American Academy of Child and Adolescent Psychiatry. (1997). Practice parameters for the assessment and treatment of children, adolescents, adults with attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 85-121.

*American Academy of Pediatrics. (2000). Clinical practice guideline: diagnosis and evaluation of the child with attention deficit/hyperactivity disorder. *Pediatrics, 105*, 1158-1170.

*American Academy of Pediatrics. (2001). Clinical practice guideline: Treatment of the school-aged child with attention-deficit/hyperactivity disorder. *Pediatrics, 108*, 1033-1044.

Conners, C. K., March, J. S., Frances, A., Wells, K. C., & Ross, R. (Eds.). (2001). Treatment of Attention-Deficit/Hyperactivity Disorder: Expert consensus guidelines. *Journal of Attention Disorders,(Suppl. 1), 4*, S-7-S-33.

Green, M., Wong, M., Atkins, D., Taylor, J., & Feinleib, M. (1999). Diagnosis of Attention-Deficit/Hyperactivity Disorder. Technical *Review #3*. Rockville: Agency for Health Care Policy and Research.

Hal Elliott, H. (2002). Attention Deficit Hyperactivity Disorder in Adults: A Guide for the Primary Care Physician. *Southern Medical Journal, 95 (7)*, 736-742.

MTA Cooperative Group. (1999). A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder: The MTA Cooperative Group. Multimodal Treatment Study of Children with ADHD. *Archives of General Psychiatry, 56*, 1073-1086.

National Institutes of Health. (1998). Diagnosis and Treatment of Attention-Deficit/Hyperactivity Disorder. *NIH Consensus Statement, 16*, 2. Washington, DC: US Government Printing Office.

Ollendick, T. H., & Prinz, R. J. (Eds.). (2002). International consensus statement on ADHD. *Clinical Child and Family PsychologyReview, 5*(2), 89-111.

Pliska, S.R., Greenhill, L.L., Crismon, M.L., et al. (2000). The Texas Children's Medication Algorithm Project: Report of the Texas Consensus Conference Panel on Medication Treatment of Childhood Attention- Deficit/Hyperactivity Disorder, part I. *Journal of the American Academy of Child & Adolescent Psychiatry, 39*, 908-919.

Pliska, S.R., Greenhill, L.L., Crismon, M.L., et al. (2000). The Texas Children's Medication Algorithm Project: Report of the Texas Consensus Conference Panel on Medication Treatment of Childhood Attention- Deficit/Hyperactivity Disorder, part II. *Journal of the American Academy of Child & Adolescent Psychiatry, 39*, 920-927.

MEDICATIONS COMMONLY USED IN THE TREATMENT OF ADHD

Stimulants*

Amphetamine Type
- Short-acting (Dexedrine® tablets)
- Intermediate-acting (Adderall®, Dexedrine Spansule®)
- Extended-release (Adderall-XR™)

Methylphenidate Type
- Short-acting (Ritalin®, Methylin®)
- D-Isomer (Focalin™)
- Intermediate-acting (Ritalin-SR®, Methylin® ER
- Metadate® ER, Metadate® CD
- Extended-release (Concerta®)

Norepinephrine Specific Agent*

- Atomoxetine (Strattera®)

Second Line Alternatives**

- Antidepressant Type
  - Tricyclics (TCAs, e.g., imipramine desipramine, nortriptyline)
  - Bupropion (Wellbutrin®, Wellbutrin SR™)
  - Venlafaxine (Effexor® XR)

Pediatric Augmenting Agents**

- Clonidine (Catapres-TTS®, Catapres®)
- Guanfacine (Tenex®)

Prescribing tips

Common stimulant side effects include appetite (but not growth) suppression, sleep problems, behavioral rebound, and transient headache or stomachache. Usually these can be addressed through patient/family reassurance and dosage adjustments before other agents are tried. If the first stimulant isn't working or if there are too many adverse side effects, try another stimulant before moving to a second line alternative.

Stimulant exacerbation of tics to a serious level is rare, but often can be handled by reducing the dose, trying a different stimulant, or augmenting with an alpha adrenergic agonist, such as clonidine or guanfacine. Low dose clonidine at bedtime is also useful to address insomnia that is unresponsive to sleep hygiene rules and other methods.

Stimulants are now thought not to significantly affect seizure threshold, and can be used in combined pharmacy with anti-seizure medications.

Emergence of psychosis, mania, severe depression, euphoria, or hallucinations should lead to reduced/ended dosing and a referral to a specialist. Emerging dysphoria/irritability can be addressed by trying a different agent, or considering the possibility of co-morbid depression.

ADHD with accompanying mild depression or mild anxiety should be treated with a psychostimulant, which may address those symptoms as well. Continued symptoms of mild anxiety/mild depression should then be addressed by switching to bupropion, atomoxetine, a TCA, or adding an SSRI, such as Zoloft®.

With patient history of drug abuse, or strong patient objection to psychostimulants, use atomoxetine or bupropion.

Adderall-XR™, Dexedrine Spansule®, Ritalin® LA ™, & Metadate® CD can be sprinkled.

TCAs require baseline ECGs, and should be used with extreme caution in patients with coronary artery disease

* FDA approved for ADHD

**Off-label for ADHD

INTERNATIONAL CONSENSUS STATEMENT ON ADHD (2002)*

Although often depicted as controversial in the public media, there is overwhelming agreement among scientists and clinicians involved in ADHD research regarding its validity and adverse impact. All major medical associations and government health agencies recognize ADHD as a genuine disorder, including the U.S. Surgeon General, the American Medical Association (AMA), the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry (AACAP), the American Psychological Association, and the American Academy of Pediatrics (AAP).

ADHD is a major public health problem and can have devastating consequences. Follow-up studies of clinical samples suggest that sufferers are far more likely to drop out of school (32-40%), fail to complete college (5-10%), have few or no friends (50-70%), under perform at work (70-80%), engage in antisocial activities (40-50%), and use tobacco or illicit drugs more than normal. Children growing up with ADHD are more likely to experience teen pregnancy (40%), sexually transmitted diseases (16%), to speed excessively and have multiple car accidents, and as adults to experience depression (20-30%) and personality disorders (18-25%). Those with ADHD are more prone to physical injury and accidental poisonings.

Hundreds of scientific studies show that ADHD involves serious deficiencies in behavioral inhibition and sustained attention that lead to impairments in major life activities, including social relations, education, family functioning, occupational functioning, self-sufficiency, and adherence to social norms.

Numerous scientific studies link the central psychological deficits in people with ADHD to several specific brain regions (the frontal lobe, its connections to the basal ganglia, and their relationship to the central aspects of the cerebellum). Most neurological studies find that those with ADHD as a group have less brain electrical activity and show less reactivity to stimulation in one or more of these specific regions. Neuroimaging studies demonstrate that those with ADHD as a group have relatively smaller areas of brain matter and less metabolic activity of this brain matter than is the case for controls.

Across various countries and multiple continents, these same psychological deficits in inhibition and attention have been found in numerous studies of identical and fraternal twins to be primarily inherited. The genetic contribution to these traits is routinely found to be among the highest for any psychiatric disorder (70-95% of trait variation in the population). While hundreds of studies show the significant effectiveness of medications, many, although not all people with this disorder, need multiple therapies, such as educational, family, and other social interventions.

* Barkley, R. (2002). International Consensus Statement on ADHD. *Clinical Child and Family Psychology Review, 5*,2.

PSYCHOSOCIAL INTERVENTIONS FOR ADHD*

Intervention	Description
Bibliotherapy	Supplies patient/family with readings/references; for information about ADHD & for specific aspects of treatment which the patient/family will self-initiate.
Psychoeducation: patient/family	Provides specific information regarding the nature and course of the disorder, treatments, use of professional, educational, and community resources.
Insight-oriented therapy	Therapy based on psychodynamic approach, aimed in part at change through gaining insight regarding past influences on present behavior. (e.g. play therapy, psychodynamic psychotherapy)
Cognitive-behavioral therapy	Therapy based upon principles of social learning and reinforcement applied to cognitive processes. Maladaptive self-talk and patterns of thinking are replaced by regular practice involving more successful mental habits.
Contingency management	Application of principles of behavior control utilizing techniques of reinforcement, response-cost, and consequence management; aimed at increasing positive (e.g.prosocial) behavior and reducing inappropriate behavior.
Clinical behavior therapy	Uses contingency management and principles of social learning theory, but also includes a wide range of cognitive, activity-based, parent/family, or other forms of treatment as needed in specific contexts. Includes behavioral contracting for adolescents.
Group therapy	Uses small-group interactions to correct inappropriate social behavior. May use both cognitive and behavioral approaches. (e.g. social skills training)
Parent training	Teaches a set of skills involving parent-child interactions such as effective communication, positive attending, and use of reward, punishment, and time-out.
Summer treatment program	Intensive and carefully structured program for teaching social and classroom coping skills, self-esteem, recreational and sports skills, and/or pharmacotherapy. May use cognitive, behavioral and medication treatment strategies.
Family Therapy	Therapy that involves the family and/or patient, usually dealing with structural issues within the family, but also dealing with family conflict, family responsibilities, and interactions affecting the patient, including marital therapy.
Extracurricular activities	Activities selected for their value in addressing particular deficits and building specific competencies, such as social skills and age appropriate intellectual skills. Includes sports or other activities to build success experiences. (e.g. Boy Scouts)
Training in time management	Provides specific instructions in prioritizing and managing daily activities at home, school, and work, using time management and organizational tools. (e.g. "ADHD coaching, and organizational skills organizational tutoring)
School-based interventions	Includes consultation with teachers and staff regarding academic and/or classroom behavioral issues. May involve psychoeducational assessment and placement (e.g. special class or initiation of services. May include behavioral and cognitive interventions as well as liaison with home-based reward systems such as daily report card. Clinicians may want to consult the 1973 Federal Rehabilitation Act (public law 93-112) and the individuals with Disabilities Education Act (IDEA) (public law 101-476, revised 1997), specifically under category other health impaired.

* Adapted from Conners, C.K., March, J.S., Frances,A., Wells, K.C., & Rosa, R. (Eds.). (2001). Treatment of Attention-Deficit/Hyperactivity Disorder: Expert consensus guidelines. *Journal of Attention Disorders, (Suppl.1), 4*, S-7-S-33.

COMMERCIALLY AVAILABLE DIAGNOSTIC TOOLS

Achenbach, T.M., & Edelbrock, C.S. (1991). *Manual for the Child Behavior Checklist and Child Behavior Profile*. Burlington, VT:University of Vermont Department of Psychiatry.
American Academy of Pediatrics. (2002). *Caring for Children With ADHD: A Resource Toolkit for Clinicians*. Washington, DC: An Initiative for Childrenis Healthcare Quality.
American Academy of Pediatrics. (2002). *ADHD: Caring for Children with ADHD: A resource toolkit for clinicians*. Elk Grove Village, Illinois: American Academy of Pediatrics.
Barkley, R.A., & Murphy, K.R. (1998). *Attention-Deficit/Hyperactivity Disorder: A Clinical Workbook*. (2nd ed.). New York, NY: Guilford.
Brown, T.E. (1996). *Brown ADD Scales*. San Antonio, TX: Psychological Corporation.
Conners, C.K. (1997). *Conners' Rating Scales-Revised*. Toronto, Canada: Multi-Health Systems, Inc.
Conners, C.K. (1997). *Conners' Rating Scales-Revised: Instruments for Use With Children and Adolescents*. New York, NY: Multi Health Systems, Inc.
DuPaul, G.J., Power, T.J., Anastopoulos, A.D., & Reid, R. (1998). *ADHD Rating Scale-IV: Checklists, Norms, and Clinical Interpretation*. New York, NY: Guilford.
Ramirez, L.F., & Sajatovic, M. (2001). *Rating Scales in Mental Health*. Hudson, OH: Lexi-Comp, Inc.
Ullman, R.K., Sleator, E.K., & Sprague, R.L. (1997). *ACTeRS: Teacher and Parent Forms Manual*. Champaign, IL: MetriTech, Inc.

This clinical practice guideline is not intended as a sole source of guidance for ADHD. Rather, it is designed to assist primary care clinicians by providing general information. It is not intended to replace clinical judgment or to establish a protocol for all ADHD patient recommendations. Clinical decisions should always be used in the context of the individual patient's situation and the clinicianis judgment of all relevant factors.

Standards for Urgent Care Centers

In conjunction with our Physician Advisory Group, BCBSNC has established standards for urgent care centers participating in our HMO, POS and PPO networks. These standards are designed to encourage a safe environment in which members might seek quality health care for urgent (not emergent) needs outside the primary care office and hospital emergency departments.

1. There must be a credentialed "urgent care physician" onsite during all hours of operation. The following specialties can be credentialed as "urgent care physicians": Family Medicine, Pediatrics, Internal Medicine and Emergency Care. Other specialties, as determined by the Credentialing Committee, may be accepted as urgent care physicians.
   - There must be a supervision policy in compliance with state regulations for all mid-level practitioners employed at the site.
2. The practice has an established quality improvement process, which includes the following:
   - Quality Improvement Committee meeting at least every six months with minutes of meetings.
   - Care processes and outcomes monitors appropriate for the practice.
3. There are written policies and procedures in place that effectively preserve patient confidentiality. The policy specifically addresses 1) how informed consent is obtained; 2) the release of any personal health information--currently existing or developed--during the course of treatment, to an outside entity, i.e., primary care physicians, specialists, hospitals, third party payers, state or federal agencies; and 3) how informed consent of release of medical records, including current and previous medical records from other providers that are part of the medical record, is obtained.
   - Medical records are secured and 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/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 and must include sufficient equipment/supplies to support life until the patient can be moved to an acute care facility.
   - Equipment cleaning procedures.
   - A fire extinguisher 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.
   - Allergies are prominently displayed in patient's records.
   - The patient's name is on every page.
5. The facility, including but not limited to reception area, exam rooms, nurses station, must be neat and orderly.
6. There are clearly marked parking spaces and 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
    - Physical status
    - Diagnostic data appropriate and in record
    - Care medically appropriate
    - Date of visit noted
    - Entries signed by provider

Free Resources to Help Your Patients Quit Smoking

Fast Facts About Tobacco Use and Abuse*:

- Tobacco use is the leading cause of preventable deaths in N.C.
- 40 percent of preventable deaths in N.C. are related to tobacco use and misuse.
- 90 percent of all tobacco users begin by age 18.
- 60 percent begin smoking by age 14.
- 25 percent of adults use tobacco products.
- 15 percent of pregnant women are tobacco users.
- 70 percent of smokers want to quit, but don't know how.

QUIT NOW NC! offers a number of free resources to help your patients quit smoking. There's also information available for their families and friends who want to help. **QUIT NOW NC!** is a partnership between N.C. Prevention Partners, the N.C. Division of Public Health's Tobacco Use Prevention and Control Branch, and the N.C. Medical Society.

Please let your patients know about some of the phone-based counseling services available in English and Spanish. These include:

- National Cancer Institute - **1-877-44U-QUIT (448-7848)**
- The American Legacy's 24/7 support line for pregnant smokers - **1-866-667-8278**
- Online counseling is also available via ***smokefree.gov***

For more information, including a directory of N.C. cessation resources, support groups and programs, visit the **QUIT NOW NC!** Web site at ***quitnownc.org***, or contact North Carolina Prevention Partners at:

North Carolina Prevention Partners
CB# 7400
Chapel Hill, NC 27599
Phone (919) 966-9137
Fax (919) 966-0981
E-mail: ***ncpreventionpartners@unc.edu***

*Fast Facts from *www.cdc.gov/nchs/fastats*



FluMist™ Intranasal Influenza Vaccine

This past June, the U.S. Food and Drug Administration approved FluMist, the first intranasal influenza vaccine, for marketing. FluMist is a live attenuated virus vaccine indicated for use in healthy children and adolescents, ages 5 to 17, and for adults ages 18 to 49. Four to six million doses are expected to be available for the 2003-2004 flu season.

FluMist may receive a lot of attention over traditional influenza vaccines because of its intranasal administration vs. injection. However, it is important to remember that **FluMist is not indicated for use in groups of patients who are at high risk for complications of influenza infection. This nasal vaccine should NOT be used for:**

- Children younger than five. In a large clinical study, young children were found to have a higher incidence of asthma and wheezing within six weeks of vaccination with FluMist compared to those who received a placebo.
- Individuals with asthma or reactive airways disease.
- Adults and children with chronic disorders of the cardiovascular or pulmonary systems.
- Pregnant women who will be in the second or third trimester during influenza season.
- Adults and children who require regular medical follow-up due to chronic metabolic diseases, such as diabetes, renal dysfunction, or hemoglobinopathies.
- Adults and children with congenital or acquired immunosuppression caused by underlying disease or immunosuppressive therapy. In addition, healthy FluMist vaccine recipients should avoid close contact with immunosuppressed persons for 21 days after vaccination.

For patients at high risk of influenza complications, injectable influenza vaccine is available. For the 2003-2004 influenza season, The Centers for Disease Control and Prevention has determined that injectable vaccine production and distribution will allow for sufficient supply during October and November. Unvaccinated individuals can continue to receive the vaccine up to and during influenza outbreaks.

FluMist is available in packages of 10 single-use sprayers. It must be stored frozen and administered shortly after being thawed. Dosing consists of two sprays, one in each nostril. Children ages 5 to 8 who have not previously received an influenza vaccine should receive a second dose of FluMist at least six weeks after the first.

FluMist is not a self-administered drug and is not covered under BCBSNC's prescription drug benefit. If administered in a physician's office, it will be reimbursed at the same level as the injectable influenza vaccine.

Please contact your BCBSNC Network Management representative if you should have any questions.

BCBSNC Network Management At Your Service

The collective goal of the BCBSNC Network Management staff is to maintain strong and effective relationships with all providers in our networks. If we can be of any assistance, please don't hesitate to contact your BCBSNC Network Management representative. Here is a list of our field offices and phone numbers for your reference and convenience.

Offices	Addresses	Numbers
Charlotte	P.O. Box 35209 Charlotte, N.C. 28235	(704) 561-2740 (Phone) (704) 676-0501 (fax)
Greensboro	2303 W. Meadowveiw Rd., Suite 200 Greensboro, N.C. 227407	(336) 316-5374 (Phone) (336) 316-0259 (fax)
Greenville	P.O. Box 1447 Greenville, N.C. 27835	(252) 758-4745 (Phone) (252) 752-6705 (fax)
Hickory	P.O. Box 1588 Hickory, N.C. 28603-1588	(877) 889-0002 (Phone) (828) 431-3155 (fax)
Raleigh	2501 Aerial Center Drive Suite 225 Morrisville, N.C. 27560	(919) 469-6935 (Phone) (919) 469-6909 (fax)
Wilmington	2005 Eastwood Road Suite 201 Wilmington, N.C. 28403	(877) 889-0001 (Phone) (910) 509-3822 (fax)



BlueCross BlueShield of North Carolina

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Ambulatory Surgical Center CPT Code Updates

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Blue Cross and Blue Shield of North Carolina (BCBSNC) will be updating our ambulatory surgical center (ASC) groupers to include 2001, 2002, and 2003 CPT code updates. Although the ASC groupings are unique to BCBSNC, we utilize nationally recognized CPT codes.

Official notification providing a thirty-day notice will be sent to ASC providers regarding this information and effective date. For your convenience, a CD-ROM that includes all of the new CPT codes and grouper mappings will be included with the notification. Please contact your local BCBSNC Network Management field office if you have any questions.