Blues today

Thank you for attending today! We value your commitment of caring for our members – your patients – and our shared goals for their improved health.
Topics for today

• Self service tools available
• Copayments
• Medical records
• Claims basics
• Prior review
• Diagnostic imaging management program
• Resources
Self service tools available on your schedule – not ours
Voice response unit (VRU)
1-800-214-4844

• Our voice recognition system offers callers speech recognition vs. slower touchtone functionality
• The system allows callers to enter information upfront for as many members as callers need information
• Calls are routed to the representative with the shortest hold time
• Representatives are specially trained for each line of business

Electronic filers, please have your NPI available
Blue e™ allows you to easily perform the following functions, in real time, from the convenience of your desktop computer – without any phone call waiting time:

- Eligibility inquiry
- Search by name for BCBSNC member identification numbers
- Medicaid eligibility inquiry
- Claims status inquiry
- Claims entry
- Batch 837 transaction claim denial listings
- Remittance check register
- Admission notification and inquiry

• Monday – Sunday: 5:00 a.m. to 1:00 a.m.
Auditing rules for claims processed on the Power MHS system, log on to see details.
Online resources – bcbsnc.com/providers/

Important News

We have collected and categorized the most recent policy updates, product updates, and company information that may be useful to you. Please visit the sections below to view the article listings for each section.

Latest Provider News – Updates

May 01, 2008  EDP Enhancement

Medical policies

Medical policy consists of medical guidelines, including diagnostic imaging policies, payment guidelines, and evidence-based guidelines.

Medical policy search

Type the policy name, number, CPT code, or keyword to search for.

[Search]

<table>
<thead>
<tr>
<th>Medical Guidelines</th>
<th>Payment Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alphabetical Index</td>
<td>Alphabetical Index</td>
</tr>
<tr>
<td>Categorical Index</td>
<td>Categorical Index</td>
</tr>
<tr>
<td>Diagostic Imaging Management Policies</td>
<td></td>
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</tbody>
</table>
Visit us!  bcbsnc.com/providers/

Some of the most widely used resources and information specifically for BCBSNC providers in one convenient location.
Copayments
Copayments

• Members with a coverage plan that includes office visit copayments are responsible for the copayment at the time services are received.

• You should collect the copayment amount listed on the member’s BCBSNC ID card when:
  − A charge for an office visit is made using an evaluation and management (E/M) code
  − Surgery is performed in the office
  − A second surgical opinion or consultation service is provided
  − The patient is seen by a physician, physician’s assistant, clinical nurse practitioner, nurse midwife, physical therapist, occupational therapist or speech therapist
Copayments

• Copayments should not be collected when there is not an E/M service code for an office visit being charged (e.g., when a member comes in to get an allergy injection, lab service only – or – a second surgical opinion, consultation or surgery is performed, in addition to the office visit).
Medical records
Requests for medical records

• When medical records are needed to complete the processing of a claim – we will notify the provider whom records are needed from – in writing – using a BCBSNC medical records request form.

  − The medical records request form contains a routing code that allows the records to be scanned and sent directly to the individual in claims review, who is waiting to complete the processing of the pending claim(s).

  − When sending medical records, always include the medical record request form, as the top sheet, on top of the medical records.

  − Do not send medical records unless requested by BCBSNC.
Medical records

Under HIPAA, if necessary, an additional authorization is needed when medical records are requested for purposes of claim processing. Providers participating with Blue Cross and Blue Shield of North Carolina should be assured that medical records requested for the purpose of claim processing fall within HHCAPA's "treatment and health care operations" as those terms are defined in the HIPAA Privacy Rule.

CM21560455101MR HRMEDREC120680907174524ILLNFP

CM21560455101MR HRMEDREC120680907174524ILLNFP

21569458210 05555 L3993 05982008

MEMBER
Medical records

• When sending medical records it’s important to return the medical record request form, placing the form on top of the medical records. The form helps direct the records to the correct location.

• Our mailrooms and front-end scanning have detailed processes to expedite scanning of the requested medical records.

• When the medical records request form is not included, or if it’s written on, or a note is attached to the medical record, we are often not able to match the medical records received with the correct member’s claim and/or route to the correct business area.
Claims basics
Claims filing

- There are three ways to electronically submit claims to BCBSNC:
  - Blue e℠ – Internet direct data entry (professional and institutional)
  - Electronic data interchange (EDI) – (professional and institutional)
  - RealMed - (professional)

Or the alternative
Claims filing

• For fastest claims processing, file electronically!
• Submit all claims within 180 days.
• Do not submit medical records unless they have been requested by BCBSNC.
• If BCBSNC is secondary and you’re sending to us the primary payor explanation of payment (EOP) with your paper claim, do not paste, tape or staple the explanation of payment to the claim form.
Claims filing

• Always verify the patient’s eligibility via the HIPAA 270 inquiry, Blue e℠, RealMed or the Provider Blue Line℠.

• Always file claims with the correct member ID number, including the alpha prefix and member suffix, whenever applicable.

• Use the appropriate provider/group NPI(s) that match the NPI(s) that is/are registered with BCBSNC for your health care business.
  
  − If you are a paper claims filer that has not applied or you have not received an NPI, or if you have not yet registered your NPI with BCBSNC, paper claims should be reported with your BCBSNC assigned provider number (and group number if applicable).
Claims filing

• BCBSNC cannot correct claims when incorrect information is submitted. Claims will be mailed back.

• Claims filing guidelines stated in the Blue Book provider manual must be followed.

• In the absence of specific BCBSNC requirements regarding coding, providers are required to follow the general coding guidelines that are published by the issuer of the coding methodology being utilized. For example, for CPT code filings, you must file the most accurate CPT codes specific to the service(s) rendered.
Claims filing with unlisted codes

• Per CPT/HCPCS coding guidelines, all unlisted codes require the submission of pertinent records, such as the operative report, detailed description of the service in question, etc… – to support the use of the unlisted code.

• This supporting information is required in order for us to make coverage and pricing determinations. By submitting it with the claim, you can prevent any payment delay that will result if we have to request medical records.

• For unlisted drugs, such as codes J3490, J3590, J9999, we require the NDC number, the name and dosage of the drug provided.

• If there is a valid CPT or HCPCS code, then do not submit a unlisted code.
Prompt pay

• BCBSNC must take one of six actions within 30 calendar days of receiving a claim:
  − Pay the claim
  − Deny the claim
  − Notify the provider that there is insufficient information to process claim
  − Notify the provider that the claim was not submitted on appropriate form
  − Notify the provider that coordination of benefits information is needed to pay the claim
  − Notify the provider that the claim cannot be processed due to non-payment of fees or premium
Claim forms

As of July 1, 2007, professional services must be reported in the revised CMS-1500 (version 08/05) format.

As of May 23, 2007, institutional/facility providers are required to submit claims in the UB-04 format.
Top reasons that can delay a claim

• Invalid, incomplete or missing member ID
  – Always include the complete member ID including applicable prefixes and suffixes as they appear on the member’s current ID card

• Invalid place-of-service code
  – Filing one-digit code instead of a two-digit code

• Missing or incorrect number of units

• Missing patient’s date of birth

• Missing onset date of symptoms

• Missing or incomplete specific diagnosis

• Missing primary payor’s EOB if BCBSNC is secondary

• Missing admission and discharge dates for inpatient claims
Claim form mail-backs

- Claims are mailed back because information needed to process the claim is missing, incomplete or invalid.
- In general, claims that are mailed back have not been entered into our claims processing systems.
- A new claim will be needed, submit a new claim not a corrected claim.
Correcting claims

• All services and/or charges must be submitted on the corrected claim:
  − Claims forms must indicate changes without erasing or marking out information that was originally submitted.
  − The resubmitted claim must be clearly marked with the title “Corrected Claim.”
  − Do not

Corrected Claim

• Remember that if a claim is mailed back to you – it is no longer in our system. When re-filing for the services, the claim is considered a new claim and not a corrected claim.
Correcting claims

• The bill type identifies a corrected UB-04 claim
eDispense™
Medicare Part D vaccine manager
eDispense™

• eDispense™ Part D Vaccine Manager, a product of Dispensing Solutions, Inc., (DSI) makes available through it’s secure online access, real-time claims processing for in-office administered Medicare Part D vaccines.

• Services offered with eDispense™ allow providers to verify member’s Medicare Part D vaccination coverage and submit claims quickly/electronically – to our pharmacy benefits manager medco® – accessed directly from providers in-office Internet connection.
eDispense™

• eDispense™ offers providers the ability to:
  - Verify members’ Medicare Part D vaccination eligibility and benefits in real-time
  - Advise members of their appropriate out-of-pocket expense for Medicare Part D vaccines
  - Submit Medicare Part D vaccine claims electronically to medco™
eDispense™

• Signing up for eDispense is easy, just go to Dispensing Solutions’ Web site and complete a simple one-time online enrollment application at enroll.edispense.com.

• Yo will need your:
  − Tax identification number
  − National provider identifier (NPI)
  − Medicare ID number
  − Drug enforcement administration (DEA) number
  − State medical license number

• Providers can contact Dispensing Solutions directly for assistance with enrollment and claims by calling their customers support center at 1-866-522-EDVM (3386).
Prior review
Prior review

- Reviews are done to confirm the following:
  - Member eligibility
  - Benefit coverage
  - Compliance with BCBSNC corporate medical policy regarding medical necessity
  - Appropriateness of setting
  - Requirements for utilization of in-network and out-of-network facilities and professionals
  - Identification of comorbidities and other problems requiring specific discharge needs
  - Identification of circumstances that may indicate a referral to concurrent review, discharge services, case management or the Member Health Partnerships™ program
Prior review

• The Prior Review list was updated on the Web site 4/1/08 for the second quarter.

• The Prior Review list is updated on a quarterly basis, within the first 10 days of January, April, July, and October. If there is no update within this time period, the list will remain unchanged until the following quarter.

• BCBSNC updates the list in advance to allow 90 days notice that a code has been added for review.
Prior review

- More information about which services require prior review, instructions on how to request prior review and the prior review list, are available on our Web site at bcbsnc.com/providers/ppa/.

<table>
<thead>
<tr>
<th>Admissions and private duty nursing</th>
<th>Diagnostic imaging</th>
<th>Prescription drugs</th>
<th>Other services and procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including skilled nursing facility admissions and private duty nursing service. Learn more or submit a request &gt;&gt;</td>
<td>Including CT/CTA, PET and MRI/MRA scans and nuclear cardiology studies. Learn more or submit a request &gt;&gt;</td>
<td>Including cox 2 inhibitors, antifungals, weight loss and allergy drugs. Learn more or submit a request &gt;&gt;</td>
<td>Such as home health care services, durable medical equipment and mental health. Learn more or submit a request &gt;&gt;</td>
</tr>
</tbody>
</table>
Prior review approval

• Providers have two Web based options for submitting requests for prior review approval.

• If contacting BCBSNC after hours to request prior review approval, you need only provide your important contact information.

• A BCBSNC representative will return your call the next day to collect complete information.

Forms are available via the prior plan approval page at bcbsnc.com/providers/ppa/
Diagnostic imaging management program
Diagnostic imaging management program

- Prior authorization is required for high-tech diagnostic imaging services when performed in a physician's office, the outpatient department of a hospital, or a freestanding imaging center:
  - CT/CTA scans
  - MRI/MRA scans
  - Nuclear cardiology studies
  - PET scans
- American Imaging Management (AIM) administers the diagnostic imaging program.
Diagnostic imaging management program

- Ordering physicians must contact AIM to obtain prior authorization before scheduling an imaging exam for outpatient diagnostic, non-emergency services.
- Servicing providers (hospitals and freestanding imaging centers) should confirm that prior authorization was issued prior to performing the service.
  - Only ordering physicians can obtain prior plan approval. Hospitals and freestanding imaging centers that perform the imaging services cannot obtain prior plan approval.

Servicing providers now have up to 72 hours after the date of service to add an additional CPT code for a contiguous-body part (e.g. adding abdomen to pelvis) to an existing AIM authorization.
Diagnostic imaging management program

The relationships balance

Ordering provider’s relationships with imaging centers and outpatient facilities where they refer

Imaging centers and outpatient facilities relationships with their reading providers and vice versa

Each have a vital role in arranging and delivering patient care and ensuring that authorizations are obtained
Diagnostic imaging management program

• Servicing facilities/offices can check member participation in the program
• Interventional radiologists have the ability to order imaging online
• Group query provides information on invalid and/or other Blues’ group numbers
• Enhanced capabilities through “Manage My Groups”
Diagnostic imaging management program – Services and locations

Included services
- Outpatient diagnostic imaging services:
  - CT, CTA
  - Nuclear cardiology (e.g. SPECT scans)
  - PET scans
  - Magnetic resonance imaging (MRI/MRA/MRS)

Locations
- Included places of service:
  - Freestanding imaging centers
  - Hospital outpatient
  - In-office use of physician-owned equipment
- Not included places of service:
  - Inpatient
  - Emergency room
  - Ambulatory surgical center
  - Urgent care center
Diagnostic imaging management program – Services

Diagnostic Imaging Prior Plan Approval Code List – 2nd Quarter 2008

*This list is subject to change once per quarter. Changes will be posted to the BCBSNC website at www.bcbsnc.com by the 10th day of January, April, July, and October.*

*NOTE: Unlisted and Miscellaneous health service codes should only be used if a specific code has not been established by the American Medical Association.*

<table>
<thead>
<tr>
<th>With Groupings</th>
<th>CPT</th>
<th>Service Description</th>
<th>Effective Date</th>
<th>Date Ineffective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdomen 6</td>
<td>74150</td>
<td>CT abdomen; w/o contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>74160</td>
<td>CT abdomen; with contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>74170</td>
<td>CT abdomen; w/o contrast followed by contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td>Chest 5</td>
<td>71250</td>
<td>CT thorax; w/o contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>71260</td>
<td>CT thorax; with contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>71270</td>
<td>CT thorax; w/o contrast followed by contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td>Upper Extremity 11</td>
<td>73200</td>
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<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>73201</td>
<td>CT upper extremity; with contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>73202</td>
<td>CT upper extremity; w/o contrast followed by contrast</td>
<td>3/15/2007</td>
<td></td>
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<tr>
<td>Lower Extremity 12</td>
<td>73700</td>
<td>CT lower extremity; w/o contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>73701</td>
<td>CT lower extremity; with contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>73702</td>
<td>CT lower extremity; w/o contrast followed by contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td>Head 3</td>
<td>70450</td>
<td>CT head or brain; w/o contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>70460</td>
<td>CT head or brain; with contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>70470</td>
<td>CT head or brain; w/o contrast followed by contrast</td>
<td>3/15/2007</td>
<td></td>
</tr>
</tbody>
</table>
Diagnostic imaging management program – Making a request?

• Request prior plan approval for diagnostic imaging procedures:
  – Online: ProviderPortal™ using Blue e™
  – By fax: Prior plan approval fax request form
  – By phone: American Imaging Management
    • 1–866–455–8414
      Monday – Friday, 8 a.m. – 5 p.m., Eastern Time
Diagnostic imaging management program – High level program participation

- **Members included:**
  - Blue Advantage
  - Blue Care
  - Blue Options
  - Blue Options FC
  - Blue Options HRA
  - Blue Options HSA
  - State Health Plan PPO
  - Food Lion
  - BCBSNC employee group

- **Members not included**
  - Blue HMO (R.J. Reynolds)
  - Classic Blue
  - Federal Employee Program
  - Medicare Supplement
  - Medicare Options
  - NC Health Choice
  - State Health Plan Indemnity (CMM)
  - Blue Card members

Inter-Plan Programs (BlueCard®) members may also have imaging programs with home plans
Diagnostic imaging management program –
Verifying participation

Diagnostic imaging procedures

The following services may require prior plan approval when rendered on a non-emergency outpatient basis, such as in a doctor’s office, the outpatient department of a hospital or a freestanding imaging center (for dates of service on or after February 25, 2007):

- CT/CTA scans
- MRA/MRA scans
- PET scans
- Nuclear cardiology studies

Some employer groups are not participating in the diagnostic imaging program. If you are unsure whether your employer group participates, you may enter the provider's name and/or the search button. The group number can be found on the member's identification card.

Group No. <123456>
Effective Date <01/01/2007>
Rx BIN <123456>
Rx PCN <123456>
Rx Group <ABCDEF>
Issuer <123456>

This member number query is required. It is an optional tool for you to use in determining program participation. Only group members covered or administered by Blue Cross and Blue Shield of North Carolina (BCBSNC) appear in this query. Most BCBSNC members are participating in the program. If you are unsure whether a member is participating, proceed with requesting an authorization. If you do not have the member's group number, you can use the Health Eligibility link in Blue e to obtain it.
Diagnostic imaging management program – Oncologic PET Scan form

Form available on bcbsnc.com/providers
Want to find out more?

• Diagnostic imaging resources on the Web
• More information – get answers to your questions about this program by reviewing the frequently asked questions.
• Medical policy information – review guidelines governing the use of diagnostic imaging procedures by reviewing our medical policies.
• Training materials @ bcbsnc.com/providers/imaging/
  • Program overview
  • Ordering Provider Quick Reference Guide
  • Servicing Provider Quick Reference Guide
  • AIM Provider Portal Quick Reference Guide
  • Troubleshooting Guide for Common Set–up Issues
  • Provider Training Presentation on BCBSNC’s Diagnostic Imaging program (with audio feature)
Resources
Resources

- Visit our Web site regularly and find out what’s new for providers at BCBSNC
- Read the Blue Link™ online newsletter for news affecting providers
- Our most current Blue Book manual is always available on the Web at bcbsnc.com/providers/
- Save yourself a phone call and use Blue e™ and/or RealMed

Keeping up and working together – smart business for everybody!
Network Management regional offices

Greensboro
1-888-298-7567

Raleigh
1-800-777-1643

Hickory
1-877-889-0002

Charlotte
1-800-754-8185

Wilmington / Greenville
1-877-889-0001 / 1-888-291-1780

BlueCross BlueShield of North Carolina

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Your questions?
– Thank you