Learning how to accurately diagnose and treat depression has never been more important for the primary care physician. Recent news articles have made us aware of how serious and life-threatening depression can be. Statistics from many studies point out that a large percentage of senior patients who complete suicide have had some contact with their primary care physician within days of their death. A recent study of primary care physicians sponsored by the National Institute of Mental Health found that physicians spent little time discussing mental health issues with older patients and rarely referred the older patient to a mental health professional. While those age 65 and older make up 12% of the population, 16% of the deaths by suicide in 2004 (last year reported) were age 65 and older. Physicians fell into three groups per the study. These groups were 1) listening to the patient for an extended time and referring to a mental health provider, 2) gathering information but not providing adequate treatment and 3) being dismissive toward the patient and his/her emotional distress and failing to follow up.

The study found that twice as many women as men discussed mental health issues during a typical visit. Women were also more apt to discuss mental health concerns with a female practitioner. This is concerning as elderly men are more likely to have a completed suicide than are elderly women. The researchers concluded that primary care physicians need more support in identifying, treating and referring patients to mental health providers.

The journal article can be found in the December 2007 issue of the Journal of the American Geriatrics Society.

In order to assist primary care physicians in assessing and treating elderly patients, the following information is offered. The diagnosis and treatment of depression can be confusing, baffling, and mystifying for many physicians. On the other hand, oversimplifying some of the complex issues found in the treatment of depression can produce potentially catastrophic outcomes.

- The first step in treating depression is to establish the diagnosis. In the senior population, the physician needs to keep a high degree of suspicion of depression, as 6-8% of all outpatients have major depressive disorder, females more often than males. The elderly patient may present with a physical complaint which is often a symptom of depression. Muscle aches, backache and headaches may have a physical cause but may also be a symptom of depression.

- Next, evaluate the patient to establish the severity of depression and identify medical illnesses that may be causing or contributing to depression, such as chronic disease, drug or alcohol abuse, hypothyroidism, hypertension, cardiac disease, and stroke.

- Assess the patient's risk for suicide or homicide and consider referral to behavioral health. The suicide assessment tip sheet published by Magellan (see MagellanHealth.com) can assist you in evaluating suicide risk.

- Next, initiate medical treatment with an appropriate antidepressant.

- Especially in our senior population it is critical to review the side effects of the medication selected with the patient. Be mindful of drug-drug interactions with other medications the patient may be taking. Stress the importance of calling the physician if side effects develop. If the patient finds a side effect intolerable, do not hesitate to change medications. Have the patient consider whether or not the side effects are worse than the actual illness. Side effects may be reduced by trying a lower dose, especially when initiating therapy.

- Monitor the patient closely, with weekly, then monthly visits. Some visits may be with a physician extender or behavioral health provider. A minimum
of three follow-up visits should be included within the first twelve weeks of initiating treatment. Emphasize the need to continue the medication, even if the patient's mood has improved.

- **Consider referral to a behavioral health specialist** for the 30-50% of patients who do not respond to simple pharmacotherapy despite the use of an effective agent at a therapeutic dose for an adequate duration.

- **Continue the medication for a minimum of six months** to reduce the likelihood of relapse and recurrence of depression. If necessary, consultation with a mental health provider is suggested.

Following these simple steps can reward you with the satisfaction of providing the most expert treatment possible to our Medicare Advantage members. Depression is an illness that has a high cure rate, far higher than many other illnesses. Identifying an illness early and treating it aggressively, especially in our senior population, are key to a successful outcome.

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Medical and drug coverage of insulin and supplies associated with the injection of insulin

The Centers for Medicare & Medicaid Services (CMS) require that drugs prescribed for conditions that could potentially be covered under either Medicare Part B or Part D be paid for under the correct benefit. As part of our efforts to comply with this requirement, we conduct periodic retrospective audits of certain claims. Results of our audit show errors in billing and payment associated with the coverage of insulin and supplies associated with the injection of insulin. Please review the following criteria requirements for payment of insulin and supplies associated with the injection of insulin:

- Coverage of insulin as a Part B medical benefit:
  - Insulin administered via insulin pump (if medically necessary).

- Coverage of insulin and supplies as a Part D prescription drug benefit:
  - Insulin injected via syringe by the beneficiary in the home.
  - “Medical supplies associated with the injection of insulin (as defined in regulations of the Secretary).” CMS defines those medical supplies to include syringes, needles, alcohol swabs and gauze.

Please note that not all members have elected to enroll in a prescription drug benefit.

In order to facilitate reimbursement under the appropriate benefit, please notify your staff of the information above. Your assistance in documenting if the member is receiving insulin via a pump or via injection will minimize delays in filling these prescriptions and assist in ensuring that the drug is covered under the correct benefit.

References:

- “Medicare Part B versus Part D coverage issues” [cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf](http://cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf)
Important message for Durable Medical Equipment (DME) providers

Oxygen equipment suppliers of oxygen equipment and services need to be aware that we will make changes in our processes for the authorization of oxygen equipment for Medicare beneficiaries as described in this article.

- For rentals prior to January 1, 2006, Section 5101(b) of the Deficit Reduction Act (DRA) of 2005 limits the total number of continuous rental months for which Medicare will pay for oxygen equipment to 36 months. After the 36th month, the beneficiary will own the oxygen equipment.
- The authorization process will still include prior approval for an initial three-month rental period for new oxygen requests followed by a 33-month rental period that would convert to purchase and the title for the oxygen equipment will transfer to the member. After transfer of the title of the stationary and/or portable oxygen equipment to the member, PARTNERS will continue to make separate monthly payments as set forth in the DME contract for gaseous or liquid oxygen contents until medical necessity ends.
- New enrollees with Blue Medicare HMO℠ and Blue Medicare PPO℠ plans that have been on oxygen since January 1, 2006 will continue to require prior approval but will not be required to submit a qualifying oxygen saturation if they have one of the diagnoses that CMS identifies as meeting the guidelines for oxygen. (These include a severe lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, whether of known or unknown etiology; cystic fibrosis bronchiectasis; widespread pulmonary neoplasm; or Hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy. Examples of these symptoms and findings are pulmonary hypertension, recurring congestive heart failure due to chronic cor pulmonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, and morning headache.)
- A change in vendor does not change the initial date of service for the purpose of meeting the 36-month rental period.

Maintenance and repairs
We are also making changes to maintenance and repairs, as follows:
- Repairs may only be billed on purchased items and require prior approval.
- Repairs may not be billed on rented equipment.
- Modifier RP must be filed when submitting claims for repairs. Reimbursement for repairs is determined on a case-by-case basis, not to exceed 75% of purchase price.
- Non-routine repairs that require the skill of a technician may be eligible for reimbursement.
- The labor component of the repair should be billed under the appropriate repair code.
- All replacement parts should be billed separately under the appropriate HCPCS code(s).
- All claims with a repair code should be submitted with a complete description of the services provided.
- When submitting a claim with a repair modifier code and other modifier codes, list the repair modifier code first after the procedure code.
- Losses resulting from abuse / misuse of equipment or items are excluded from coverage.

Visit the providers page at bcbsnc.com/providers
Reminders about Blue Medicare HMO<sup>SM</sup> and Blue Medicare PPO<sup>SM</sup>

Blue Medicare HMO and Blue Medicare PPO are the names for our PARTNERS health care benefit plans. Beginning January 1, 2008, your patients enrolled in PARTNERS health care benefit plans have new identification cards with a Blue look. The new member identification cards display a Blue Medicare HMO or Blue Medicare PPO product name and a Blue Cross and Blue Shield emblem. We’ve made these changes to identify PARTNERS as an affiliate of the larger Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

While our product names have changed, our commitment to improving the health of our members is ever present. We appreciate the care that you provide to our members – your patients, and we’ll continue the same personalized provider services, claims services and health care management services from our Winston-Salem-based locations.

Release of Medicare Advantage appeals notices

PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS), its parent company administrator, Blue Cross and Blue Shield of North Carolina (BCBSNC), and its associated delegates require practitioners, providers and staff who make utilization management-related decisions to make those decisions solely based on appropriateness of care and service and existence of coverage. PARTNERS does not compensate or provide any other incentives to any practitioner or other individual conducting utilization management review to encourage denials. PARTNERS makes it clear to all staff who make utilization management decisions that no compensation or incentives are in any way meant to encourage decisions that would result in barriers to care, service or underutilization of services.

PARTNERS member’s alpha prefixes

Alpha prefixes help you to identify which plan a member has enrolled, even if you do not have the member’s identification card in hand.

- **YPW** – Blue Medicare HMO<sup>SM</sup>
- **YPF** – Blue Medicare PPO<sup>SM</sup>
- **YPJ** – Blue Medicare HMO<sup>SM</sup> for Reynolds American Inc. retirees

It’s easy to distinguish between Blue Medicare HMO members and Blue Medicare PPO members. Just look at the alpha prefix at the beginning of the member’s Blue Medicare identification code. The alpha prefix YPW lets you know that the member’s coverage type is an HMO plan, and if you see YPF, you’ll know the coverage type is PPO. Additionally, Reynolds American Inc. retirees have a customized alpha prefix of YPJ, making them easy to identify as having a unique HMO plan.

By using the member’s alpha prefix, you can tell at a glance if a member has a HMO or PPO plan, and by submitting claims with the member’s identification code (including the fourth letter of J), we can quickly direct claims for processing, speeding up eligible payments to you.

Blue Medicare HMO and Blue Medicare PPO plans are offered by PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS), a subsidiary of Blue Cross and Blue Shield of North Carolina (BCBSNC). PARTNERS is a Medicare Advantage organization with a Medicare contract to provide HMO and PPO plans. Plans are administered by BCBSNC. BCBSNC and PARTNERS are independent licensees of the Blue Cross and Blue Shield Association.
PARTNERS members received new identification cards that became effective on January 1, 2008. The cards replaced our member’s previous Medicare Choice and Medicare Options identification cards. Displayed below is a sample of the replacement cards design:

A Blue Medicare member’s complete identification code includes four essential pieces of information (use the sample member identification code from the sample card image above as an example):

YPW J 12345678 01

YPW – Member’s alpha prefix – the alpha prefix helps to identify what plan type the member has been enrolled (YPW = HMO and YPF = PPO).

J – A single alpha character that is used in conjunction with the member’s identifying numeric code and essential for claims routing and processing.

12345678 – Part of the member’s identifying numeric code – as part of our on-going efforts to help protect member’s privacy, PARTNERS assigns member identification codes by use of randomly selected numbers instead of using Social Security numbers.

01 – Member’s numeric suffix – the numeric suffix helps to identify the specific member covered under the subscriber’s policy.

Important reminder: Effective January 1, 2008, all Medicare Choice and Medicare Options membership are enrolled in the newly named Blue Medicare products. In order to receive accurate and timely payment for your services, please ensure that claims are submitted to PARTNERS using the member’s Blue Medicare information. Members are required to present their new Blue Medicare identification card, in advance, or at the time of scheduled appointments. Providers are encouraged to make copies of both the front and back images of the member’s Blue Medicare identification card. Copies should be kept in the member’s file for your records and please ensure that any discarded copies are properly destroyed to help protect the patient’s identity.
Utilization management affirmative action statement

PARTNERS wants to remind you that in November 2007, the Centers for Medicare & Medicaid Services (CMS) released the following revised notices and corresponding form instructions for use by Medicare Advantage (MA) Organizations, Cost Plans and Health Care Prepayment Plans:

- Notice of Denial of Medical Coverage (NDMC);
- Notice of Denial of Payment (NDP);
- Notice of Medicare Non-Coverage (NOMNC); and
- Detailed Explanation of Non-Coverage (DENC).

The expiration dates for these notices have been extended to August 31, 2010. In addition to the extended expiration date, in some cases, minor modifications have been made to the notices and corresponding form instructions. For example, previous references to “MA plan” have been changed to “Medicare Health plan.” Plans are expected to begin using the new versions of these forms and form instructions within 90 days of the date of this memorandum.

Detailed guidance about the use of these notices appears in the form instructions that correspond with these notices and in Chapter 13 of the Medicare Managed Care Manual. The new versions of the appeals notices, the form instructions and the current version of Chapter 13 are available on CMS’s Web site at: cms.hhs.gov/MMCAG/.

Be Active Now® physical activity program

Members of Blue Medicare HMO and Blue Medicare PPO plans now have access to a new physical activity program called Be Active Now (BAN). This innovative program focuses on improving health and functional ability, promoting independence, and preventing chronic disease and disability. BAN is administered by Be Active North Carolina, a statewide non-profit dedicated to promoting physical activity and healthy lifestyles.

Members can access two Be Active Now programs at little or no additional charge.** Active Steps is a walking program that is self-directed, pedometer-based, and it works anywhere that walking is safe. The second program offers members access to a variety of individual or group physical activity/fitness programs at contracted fitness facilities.

Members who enroll in Active Steps will receive an easy to use pedometer (one per member), at no additional charge and instructions on how to start a walking program. Members can order a pedometer by calling 1-888-6FIT NOW or 1-888-634-8669.

To enroll in a physical activity/fitness program at a contracted fitness facility, members must visit the facility and present a current driver’s license or photo ID, and members must also present a current Blue Medicare HMO or Blue Medicare PPO ID card. For more information about the Be Active Now program or to locate a contracted fitness facility, please contact our Customer Service Department from 8:00 a.m. - 8:00 p.m. daily by calling 1-888-310-4110 (HMO) or 1-888-451-9957 (PPO) (TTY/TDD users call 1-877-494-7647) or visit the Be Active Now Web site at beactivenc.org.

According to the Centers for Disease Control and Prevention, all adults, including older adults, should engage in 30 minutes of moderate-intensity physical activity at least five or more days per week. Physical activity is known to be essential in the prevention and management of chronic diseases; therefore, health care providers play a vital role in motivating patients to begin physical activity programs such as Be Active Now. Encourage your patients to be physically active and counsel them to engage in a program of regular physical activity that is tailored to their health status and personal lifestyle.

** Blue Medicare HMO and Blue Medicare PPO plans cover most contracted fitness facilities fees in full. Members should contact the Sales Department or refer to their Evidence of Coverage for cost.
Effective December 01, 2008, the Prior Authorization Guidelines are being updated to include the following changes. A copy of the new guidelines is included in this newsletter.

Services removed from Prior Authorization Guidelines:
- Rhinoplasty
- Genioplasty/sliding osteotomy
- Strabismus surgery
- External counterpulsation
- Hospice
- Biofeedback
- Implantable cardiac defibrillators
- Lithotripsy, extracorporeal for orthopedic procedures
- Capsulotomy, Yag LASER
- Retina, central photocoagulation
- LASER
- Pan-retinal photocoagulation PRP, LASER
- Photodynamic therapy with visudyne

Service added to the Prior Authorization Guidelines:
- Sacral nerve stimulator

The Prior Authorization Guidelines can be located on the BCBSNC Web site at: bcbsnc.com/providers/blue-medicare-providers/policies-and-responsibilities/prior-authorization.cfm. If you have questions regarding the Prior Approval Guidelines please contact your network services representative at BCBSNC.

Visit the providers page at bcbsnc.com/providers
Recently, the Centers for Medicare and Medicaid Services (CMS) announced it has approved BCBSNC’s application to expand into 14 additional counties. As a result, at this fall’s open enrollment, Blue Medicare HMO and Blue Medicare PPO will now be available in 51 North Carolina counties, including counties located in the Triangle, the Triad, and the Charlotte area. These services also extend to eastern North Carolina to include Greenville and Wilmington. Counties shaded in blue identify our combined existing and expansion networks availability.

PARTNERS products – recognizing our logos

PARTNERS Blue Medicare product logos are easily recognizable. They incorporate the signature Blue Cross and Blue Shield “blue” and provide text that the plans are: “Offered by PARTNERS National Health Plans of North Carolina, Inc.”

Blue Medicare HMO

Offered by PARTNERS National Health Plans of North Carolina, Inc.

Blue Medicare PPO

Offered by PARTNERS National Health Plans of North Carolina, Inc.
Important information about our product logos

Our product logos make our Blue Medicare HMO℠ and Blue Medicare PPO℠ plans more recognizable as an affiliate of the Blue Cross and Blue Shield Association. However, it's important to remember that Blue Medicare HMO and Blue Medicare PPO plans are offered by PARTNERS National Health Plans of North Carolina, Inc., and claims for services should be filed to PARTNERS and not Blue Cross and Blue Shield of North Carolina (BCBSNC).

Blue Medicare HMO and Blue Medicare PPO are PARTNERS replacement names of our former Medicare Choice and Medicare Options HMO and PPO health care benefit plans. Blue Medicare Rx is prescription drug coverage for Medicare beneficiaries, which is sponsored by Medicare and provided through BCBSNC. Blue Medicare Supplement are supplemental health plans offered by BCBSNC for Medicare beneficiaries enrolled in Medicare Part B. To learn more about Blue Medicare

Distinguishing among Blue Medicare product types:

**PARTNERS products**

![Blue Medicare HMO℠](image)

Offered by PARTNERS National Health Plans of North Carolina, Inc.

![Blue Medicare PPO℠](image)

Offered by PARTNERS National Health Plans of North Carolina, Inc.

**BCBSNC products**

![Blue Medicare Rx℠](image)

![Blue Medicare Supplement℠](image)

Rx and/or Blue Medicare Supplement visit the BCBSNC Web site at: [bcbsnc.com/plans/medicareplans.cfm](http://bcbsnc.com/plans/medicareplans.cfm).

Claims filing for Blue Medicare plans

At PARTNERS we want your claims filed to us electronically. However, if you’re still submitting claims on paper, we want those too! Send your paper claims for Blue Medicare HMO℠ and Blue Medicare PPO℠ members to our Winston-Salem mailing addresses.

Claims for services provided to Blue Medicare HMO and Blue Medicare PPO members should be submitted electronically (or by paper when necessary) to PARTNERS National Health Plans of North Carolina, Inc. Claims sent in error to BCBSNC for Blue Medicare HMO and PPO members (filed electronically or by mail) will be returned to the submitting provider, which will result in delayed payments.

Mailing addresses for PARTNERS

Blue Medicare HMO and Blue Medicare PPO

**Main mailing address**

PARTNERS

P.O. Box 17509

Winston-Salem, NC 27116-7509

**FedEx, UPS and 4th Class**

PARTNERS

5660 University Parkway

Winston-Salem, NC 27105-1312
As part of our 2008 member benefit enhancements, PARTNERS HMO members* are no longer required to obtain referrals from their primary care physician in advance of receiving care from a participating specialist or when obtaining home durable medical equipment. However, it’s important to note that this change in HMO procedure does not impact prior plan approval guidelines and pre-certification/certification requirements. Additionally, members are still required to choose a primary care physician, and primary care physicians continue their responsibility to coordinate HMO members’ care.

*Referrals from primary care physicians in advance of receiving care from a specialist or when obtaining home durable medical equipment remains a requirement for Blue Medicare HMO-RAI members (RAI, Reynolds American Incorporated).

PARTNERS makes information readily available on the Web. Publishing on the Web helps us to ensure that the information you receive from PARTNERS is the most current and accurate information available. The Web can be accessed to find information about PARTNERS prior plan approval, health care coverage options and benefits, medication formularies, network providers, provider newsletters and manuals, and more continues. You can find us at the BCBSNC Web site bcbsnc.com along with the answers to your PARTNERS questions.
Surveys show that Spanish-speaking individuals are at a disadvantage when communicating with a non-Spanish-speaking health care provider. Communication problems for Spanish-speaking patients can include difficulties asking their providers questions, understanding information from a provider’s office and understanding instructions for prescription medicine. If you don’t speak any Spanish or if you are not fluent in Spanish, there are other ways you can enhance communication with your Latino patients. Here are some suggestions:

- **When speaking Spanish, use the formal (usted) instead of the informal (tú).** Try to avoid calling patients by their first name. Instead, use “Mr.,” “Mrs.,” or “Miss” (Señor, Señora or Señorita).

- **Ask some warm-up questions about your patient’s family, job, etc.** This will help you gain trust. Showing sincere interest in your patient’s life and using friendly body language can make your patient more comfortable about sharing their health information.

- **Health matters are often a family decision for Latinos.** Allow the family time to discuss information and come up with questions.

- **Encourage questions.** In the Latino culture, doctors are often viewed as authority figures; it is considered impolite to question their knowledge or look them in the eye. Don’t ask Latino patients “Do you understand?” Instead, ask them to rephrase the information by saying “Please explain to me what I’ve just told you.”

- **Explain to female patients why you need answers to personal questions.** If the patient is hesitant to answer questions involving sexual practices, it may be that she is embarrassed to share her personal information. She may be more comfortable speaking to a female. Explain why it is important to collect all this information and assure her that her medical information is considered confidential.

- **Ask about traditional remedies or imported drugs that the patient may be taking.** Latino stores sometimes provide drugs and herbal medicine. Patients may be using home remedies or self-medicating with such drugs or drugs given to them by friends or relatives. Imported medicines may have the same name as U.S. brands, but are sometimes marketed with different names. Ask your patients to bring any medications they are taking to their visit so you can determine the medicinal equivalents.

- **Patients may sometimes delay taking medicines unless they think it is the last option.** Help your patient understand their prescription – what it is for, how to take it, how many days, how many times per day, side effects and what to do if they miss a dose or in case of overdose. Helping your patient understand their prescription will increase the chances that they will take it correctly and complete the treatment.

- **When available, have Spanish-language health educational materials on hand.** Use services from a professional interpreter when possible.

### Finding an interpreter

In North Carolina, providers can locate an interpreter to assist in communicating with Spanish-speaking and other foreign-language-speaking patients through the Carolina Association of Translators and Interpreters (CATI). CATI is an association of working translators and interpreters in North Carolina and South Carolina and is a chapter of the American Translators Association. CATI provides contact information of translators and interpreters within North Carolina at www.catiweb.org/index.htm.

### Five useful Spanish health phrases

<table>
<thead>
<tr>
<th>phrase</th>
<th>translation</th>
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<tbody>
<tr>
<td>Soy el doctor (male) / Soy la doctora (female)</td>
<td>I am a doctor…</td>
</tr>
<tr>
<td>Cómo se siente hoy?</td>
<td>How are you feeling today?</td>
</tr>
<tr>
<td>Dónde le duele?</td>
<td>Where does it hurt?</td>
</tr>
<tr>
<td>Qué medicina o remedios caseros está tomando?</td>
<td>What medicines or home remedies are you taking?</td>
</tr>
<tr>
<td>Su próxima cita es…</td>
<td>Your next appointment is…</td>
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</table>
Important reminder about billing for vaccine administration

Physicians and other providers who bill Medicare carriers or Medicare Administrative Contractors (A/B MACs) for the administration of Part D-covered vaccines to Medicare beneficiaries should be aware of article Special Edition (SE) 0723. This article provides 2008 payment guidance for the administration of Part D-covered vaccines. However, this is not new policy guidance; it’s just a reminder of the policy for 2008.

Remember, effective January 1, 2008, physicians can no longer bill Medicare Part B (i.e. PARTNERS medical claims) for the administration of Medicare Part D-covered vaccines, using the special G code (G0377). Instead, you will need to bill the patient for the vaccine and its administration, and the patient will need to submit the claim to their Part D plan for reimbursement. You should make sure that your billing staff is aware of this Part D-covered vaccine administration guidance for 2008.

Providers enrolled in eDispense™ can submit Medicare Part D vaccine claims electronically to Medco® for direct reimbursement. More about the benefits of eDispense can be found on page 15 of this publication.

Section 202(b) of the Tax Relief and Health Care Act of 2006 (TRHCA) established a permanent policy for payment by Medicare for administration of Part D-covered vaccines, beginning in 2008. Specifically, the policy states that, effective January 1, 2008, the administration of a Part D-covered vaccine is included in the definition of “covered Part D drug” under the Part D statute. During 2007, in transition to this new policy, providers were permitted to bill Part B for the administration of a Part D vaccine using a special G code (G0377).

SE0723 now reminds providers of the requirement that payment for the administration of Part D covered vaccines only during 2007.

Therefore, effective January 1, 2008, you can no longer bill the G code to Part B.

Important note: This guidance does not affect Part B-covered vaccines. You might want to look at MLN Matters articles MM5486 (Payment by DME MACs and DMERCs for the Administration of Part D Vaccines), released December 29, 2006; and MM5459 (Emergency Update to the 2007 Medicare Physician Fee Schedule Database (MPFSDB)) released January 11, 2007.

You can find these articles at cms.hhs.gov/MLNMattersArticles/downloads/MM5486.pdf and cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf, respectively.

You may also want to review SE0727 (Reimbursement for Vaccines and Vaccine Administration under Medicare Part D), which may be found at cms.hhs.gov/MLNMattersArticles/downloads/SE0727.pdf on the CMS Web site.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.
PARTNERS is compliant with the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA), which requires a national standard identifier for health care providers. That standard identifier – the National Provider Identifier (NPI) – was scheduled to be in place by May 23, 2008 for all providers submitting health care transactions electronically.

PARTNERS worked diligently to meet the May 23, 2008 NPI Compliance deadline and would like to thank our provider community for their assistance. Provider participation and feedback provided us with valuable information to assist in our NPI implementation. The following information may be helpful as you work towards NPI Compliance and integration:

**How to apply for your NPI:**
CMS contracted with Fox Systems to be the enumerator responsible for administering the assignment of the NPI(s) to providers. Providers may apply via a Web site or by submitting a paper application. To apply for NPI at NPPES, visit:

nppes.cms.hhs.gov/NPPES/Welcome.doc

The following CMS sources can provide you with updates and information about NPI:
CMS NPI online resources can be accessed at:

cms.hhs.gov/HIPAAGenInfo

cms.hhs.gov/NationalProvidentStand

PARTNERS contracts with Blue Cross and Blue Shield of North Carolina (BCBSNC) for certain services, these services allow providers to register their NPI with BCBSNC and the information to be passed to PARTNERS National Health Plans of North Carolina, Inc. If you have not registered your NPI with BCBSNC, please register as soon as possible.

You may register with BCBSNC by contacting your Network Management regional representative.

Providers are encouraged to obtain and incorporate the NPI into their office practices accordingly.

Here are some helpful suggestions to ensure a smooth transition:

- Register all NPIs for your organization and its associated individuals with all payors (including new providers joining your practice);
- Work with all payors to understand how they implemented the NPI HIPAA-mandate and what it means to your relationship with that payer;
- Work with your software vendor and/or clearinghouse for NPI-related issues including (but not limited to) transmission problems, placement of NPIs on transactions and claim rejection discrepancies.

If you have other questions or are ready to register your NPI, please contact your local Network Management representative:

<table>
<thead>
<tr>
<th>Office location</th>
<th>Toll-free number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charlotte</td>
<td>(800) 754-8185</td>
</tr>
<tr>
<td>Greensboro</td>
<td>(888) 298-7567</td>
</tr>
<tr>
<td>Greenville</td>
<td>(888) 291-1780</td>
</tr>
<tr>
<td>Hickory</td>
<td>(877) 889-0002</td>
</tr>
<tr>
<td>Raleigh</td>
<td>(800) 777-1643</td>
</tr>
<tr>
<td>Wilmington</td>
<td>(877) 889-0001</td>
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</tbody>
</table>
Network Management is here for you

Network Management is responsible for developing and supporting relationships with the provider community. Network Management staff is dedicated to serving as a liaison between you and PARTNERS and are available to assist you with a variety of issues, including:

- Questions regarding PARTNERS contracts, policies and procedures
- Changes to your organization including:
  - Opening/closing locations
  - Change in name or ownership
  - Change in tax ID number, address or phone number
  - Merging with another group
  - Educational needs

Network Management field offices are located throughout the state and are assigned to support the provider community by specific geographical region. Please contact one of our Network Management offices whenever you need our assistance.

**Hickory Office**
P.O. Box 1588
Hickory, NC 28601
Phone: 1-877-889-0002
Fax: 1-828-431-3155

**Greenville/Fayetteville/Wilmington Offices**
2005 Eastwood Road
Suite 201
Wilmington, NC 28403
Phone: 1-877-889-0001
Fax: 1-910-509-3822

**Charlotte Office**
P.O. Box 35209
Charlotte, NC 28235
Phone: 1-800-754-8185
Fax: 1-704-676-0501

**Greensboro Office**
The Kinston Building
2303 W. Meadowview Road
Greensboro, NC 27407
Phone: 1-888-298-7567
Fax: 1-336-316-0259

**Raleigh Office**
P.O. Box 2291
Durham, NC 27702
Phone: 1-800-777-1643
Fax: 1-919-469-6909
Safe handling of vaccines

Disease prevention can be one of the most important steps to good health. It’s always better to prevent a disease than to treat it – making vaccines an important part of your patients care. By vaccinating your patients you can help to protect them from certain diseases. However, this protection can be lost if vaccines are not properly stored and handled. Vaccines should always be transported and stored at their proper temperature. Vaccines can be temperature sensitive and should be monitored for temperature increases and decreases until they are administered. Members should never be asked to pick-up vaccines from the pharmacy for transport to a provider’s office, as this may result in unsafe temperature changes.

Office-administered vaccines eligible under a member’s Part D pharmacy benefit are to be obtained from the administering health care provider and a member should never be requested to obtain a vaccine from a pharmacy for an in-office vaccination.
HealthTrio connect™

PARTNERS, together with HealthTrio connect, utilizes the power of the Internet to deliver a comprehensive suite of administrative transactions – all with secure messaging to enable HIPAA-compliant communication. HealthTrio connect allows you to perform the following easily, from your desktop and in real-time:

- Check claim status
- View an EOP of a processed claim or claims
- Verify member eligibility and benefits information
- Check referral status
- Obtain provider demographics

HealthTrio connect streamlines many office management tasks that have traditionally been manual, paper or done by phone. To find out more about HealthTrio connect and how to connect for your office, visit us on the Web at bcbsnc.com/providers/blue-medicare-providers/electronic-commerce/ or call PARTNERS Provider Services 1-888-296-9790.

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Important message for providers who participate with BCBSNC and utilize Blue e℠

HealthTrio connect is the secure Internet site for conducting electronic transactions with PARTNERS National Health Plans of North Carolina, Inc. If your health care business utilizes Blue e for electronic transactions, it’s important to note that Blue e can’t conduct transactions for Blue Medicare HMO℠ or Blue Medicare PPO℠ PARTNERS products. Claims activity for Blue Medicare HMO and Blue Medicare PPO by use of Blue e will be rejected by the Blue e system.

Providers should be aware that neither an individual’s possession of a Blue Medicare member identification card nor information contained in this mailing represents a guarantee of member’s benefits, eligibility or coverage in a Blue Medicare plan. Member’s actual Blue Medicare eligibility and benefits should always be verified in advance of providing services.