Medicare Advantage and Part-D compliance training reminder

Participating providers are aware that PARTNERS National Health Plan of North Carolina, Inc. (PARTNERS) has a contract with the Centers for Medicare & Medicaid Services (CMS) to provide Medicare Advantage Plans. The services that you provide help us fulfill our contractual obligations with the federal government.

On December 5, 2007, CMS issued a final rule clarifying requirements for Medicare subcontractors, including Medicare Advantage providers. This rule requires that all such providers participate in CMS-approved compliance programs.

Beginning January 1, 2009, a new training requirement was instituted that, in general, requires the following:

1. Compliance training – All of your employees working under our contract with you must complete annual Medicare compliance training.

2. Notification of the Fraud hotline – All personnel working on our contract must be informed about our Special Investigation Unit’s (SIU) hotline number for reporting suspected fraud, waste or abuse of noncompliance with Medicare rules.

3. Subcontractor involvement – Any subcontractors working on our contract must be made aware of these requirements, take the compliance training and be informed of our fraud hotline number.

The Special Investigation Unit’s (SIU) hotline number for reporting suspected fraud, waste or abuse or noncompliance with Medicare rules is 1-800-324-4963.

As an available option to fulfill this training requirement, we’ve partnered with the nationally recognized National Health Care Anti-Fraud Association (NHCAA) and the Blue Cross and Blue Shield Association (BCBSA) to develop a computer-based training program entitled, “Medicare Advantage and Part-D Compliance Training – Recognizing and Reporting Fraud Waste and Abuse.” This training has been reviewed by CMS and should satisfy the training requirement under your other Medicare Advantage contracts, in addition to your agreement(s) with PARTNERS.

Our vendor, LearnSomething, Inc. will administer the online mandatory training, which includes an access fee. We have arranged a discounted rate of $14.95 per person. Bulk rates are also available through the vendor. The online training can be accessed from the Blue Cross and Blue Shield of North Carolina (BCBSNC) Web site at bcbsnc.com/content/providers/blue-medicare-providers/training.htm.

Please note that if your organization has completed a CMS-approved training through another organization, you may not have to retake the training. We’ll just need a record of completion or an attestation form, which will be requested at a later date. If the course was completed through our vendor, but sponsored by another organization, you will not need to submit an attestation form.

We thank you in advance for your cooperation. If you have any questions or concerns, please contact your regional Network Management representative.
Chiropractic benefits change reminder

We want to remind providers that as of January 1, 2009, chiropractic benefits for Blue Medicare HMO and Blue Medicare PPO members are limited to only the services that traditional Medicare covers. Currently, services covered by traditional Medicare include manual manipulation of the spine to correct subluxation. Other services, such as X-rays taken in the chiropractor’s office, massage, electric stimulation and other forms of treatment and therapy given in the chiropractor’s office are not covered benefits as part of the Blue Medicare HMO or Blue Medicare PPO plans.

Member copayments for therapy services provided in the patient’s home

Members receiving physical, occupational and/or speech therapy services in the home may be subject to copayments and/or deductibles if they are not homebound. Blue Medicare HMO and Blue Medicare PPO members may be considered homebound and eligible for home health benefits when confined to the patient’s home and under a plan of treatment that is established, periodically reviewed and approved by a physician, and in need of physical, occupational and/or speech therapy. When services are provided in the home and do not meet the criteria for homebound, services should be billed as performed in a private residence (place of service 12 on a CMS-1500 claim form) and submitted for reimbursement as part of the member’s medical benefit, independent from home health benefits typically billed on a UB-04 claim form.
Have you heard about the Blue Medicare HMO℠ and Blue Medicare PPO℠ disease management and care management programs?

We offer disease management programs for:
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes

We offer care management programs for:
- Patients who have multiple or sufficiently severe chronic conditions
- Patients who need assistance with the management of their health care needs

With expertise in chronic conditions, our nurses can provide monitoring and interventions by phone to participating patients. Through our programs, our specially trained nurses:
- Monitor and assess patient symptoms
- Provide education to patients and/or their caregiver about their chronic conditions, co-morbidities, lifestyle choices and medications
- Communicate and collaborate with patients’ families and physicians
- Provide information regarding community resources to help patients better manage their health

Together with patients’ physicians and other health care providers, Blue Medicare HMO and Blue Medicare PPO disease and care management programs empower individuals to effectively manage chronic illness and prevent complications. Providing early assessment and timely interventions can make a difference in the health outcomes of your patients. Patient participation is voluntary and there is no cost to the patient. For more information, or to refer one of your patients to the program, please contact us at 1-800-942-5695, ext. 14386, Monday through Friday 8:00 a.m. – 5:00 p.m.

One-time ultrasound screening for abdominal aortic aneurysms

Abdominal Aortic Aneurysm (AAA) is a vascular disease with life-threatening implications. Medicare provides coverage for a one-time ultrasound screening for abdominal aortic aneurysm for patients who meet the following criteria:
- The patient has never had an AAA ultrasound screening paid for by Medicare.
- The patient has at least one of the following risk factors:
  - A family history of abdominal aortic aneurysm
  - The patient is a male, age 65 to 75, who has smoked at least 100 cigarettes in his lifetime

You play an important role in promoting, providing and educating Medicare patients about preventive services and screenings. Continue to encourage your Blue Medicare HMO and Blue Medicare PPO patients to take advantage of their preventive health benefits.

Attention home infusion therapy providers:
Catheter care is on a per diem basis (per the HCPCS code descriptions and in compliance with HIPAA) and includes separate billing for heparin and saline.
Hospital discharge appeal rights

We want to remind you that effective July 2, 2007, the Centers for Medicare & Medicaid Services (CMS) implemented new requirements for the delivery of notices regarding hospital discharge appeal rights. Under the requirements, Blue Medicare HMO\textsuperscript{SM} or Blue Medicare PPO\textsuperscript{SM} members being considered for discharge are to receive an explanation of their rights as hospital patients, including discharge appeal rights. To explain these rights, hospitals are to use the Important Message from Medicare (IM [a statutorily required notice]). The IM notice must be issued within two calendar days of admission; a signature of the member or his or her representative must be obtained on the IM; and a copy of the IM must be provided to the member or his or her representative at that time. Hospitals must also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than two calendar days before discharge.

If a PARTNERS member requests a quality improvement organization (QIO) review, PARTNERS will deliver a detailed notice of discharge (detailed notice) as soon as possible, but no later than noon of the day after the QIO’s notification. Both the IM and the detailed notice must be the standardized notices provided by CMS. Copies of the standardized notices are available from the CMS Web site at www.cms.hhs.gov/bni. Hospitals may not deviate from the content of the form except where indicated. The Office of Management and Budget (OMB) control number must be displayed on the notice. These requirements apply to any facility providing care at the inpatient hospital level, whether that care is short-term or long-term, acute or non-acute, limited to specialty care or providing a broader spectrum of services, and includes critical access hospitals. However, swing beds in hospitals are excluded because they are considered a lower level of care. Additionally, religious, non-medical health care institutions are also excluded.

To learn more about hospital discharge appeal notices and their requirements, visit the CMS Web site at www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Prior authorization guidelines revised

Effective January 1, 2010, the Prior Authorization Guidelines – included in this newsletter – are being updated to reflect the removal of the following services:

- Wound care clinic
- Initial cardiac rehabilitation program (36 program visits during a 16-week period). Additional rehabilitation requires prior approval.
- Initial pulmonary rehabilitation program (31 program visits during 16-week period). Additional rehabilitation requires prior approval.

Please review the Guidelines carefully to ensure that the services on this list are prior approved before the service is provided.


If you have questions regarding the Prior Authorization Guidelines, please contact your regional BCBSNC Network Management representative.
Prior authorization guidelines revised  (Continued from page 4)

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**Prior Authorization Guidelines**

Services marked by a bullet in the columns to the left require prior authorization for the designated line of business.

<table>
<thead>
<tr>
<th>HMO</th>
<th>PPO</th>
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<tr>
<td><strong>Cosmetic Procedures (or those potentially cosmetic), such as but not limited to:</strong></td>
<td><strong>Cosmetic Procedures (or those potentially cosmetic), such as but not limited to:</strong></td>
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<td>- Abdominoplasty</td>
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<td>- Blepharoplasty</td>
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<td>- Breast Reduction</td>
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<td><strong>Dental Services</strong></td>
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<td>- Neuropsychological Testing</td>
<td>- Neuropsychological Testing</td>
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<td>- Psychological Evaluations for medical reasons</td>
<td>- Psychological Evaluations for medical reasons</td>
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<td><strong>Durable Medical Equipment (See Prosthetics listed separately below)</strong></td>
<td><strong>Durable Medical Equipment (See Prosthetics listed separately below)</strong></td>
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<td>- All Rental Items</td>
<td>- All Rental Items</td>
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<td>- Items &gt; $500.00 (Purchase)</td>
<td>- Items &gt; $500.00 (Purchase)</td>
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<td>- Penile Implants</td>
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<td><strong>Home Health Agency Services</strong></td>
<td><strong>Home Health Agency Services</strong></td>
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<td><strong>Inpatient Admissions</strong></td>
<td><strong>Inpatient Admissions</strong></td>
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<td>- Scheduled admissions, including acute hospital admissions, acute-to-acute hospital transfers, rehabilitation facility, hospice and skilled nursing facility admissions.</td>
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<td><strong>NOTE:</strong> For urgent/emergency admits (including obstetric admits), prior authorization is NOT required. However, notification of urgent/emergency admits (including obstetric admits) within 24 hour or the first business day after the admission is required.</td>
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<td><strong>Investigational Procedures (or those potentially investigational)</strong></td>
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<td><strong>Nonparticipating Providers and Services</strong></td>
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<td><strong>Pharmaceuticals (See formulary)</strong></td>
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<td><strong>Prosthetics</strong></td>
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<td><strong>Rehabilitation/Therapy</strong></td>
<td><strong>Rehabilitation/Therapy</strong></td>
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<tr>
<td>- Cardiac Rehabilitation Initial 30 visits during a 12-week period are covered without PA. Additional rehab, requires PA</td>
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<tr>
<td>- Pulmonary Rehabilitation Initial 31 visits during a 16-week period are covered without PA. Additional rehab, requires PA</td>
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<td>- Speech Therapy</td>
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<td><strong>Surgery</strong></td>
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<td>- Extracapsular cataract extraction with intraocular lens</td>
<td>- Extracapsular cataract extraction with intraocular lens</td>
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<td>- MOHS Surgery</td>
<td>- MOHS Surgery</td>
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<td>- Refractive Surgical Procedures</td>
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<td>- Sacral Neurostimulators</td>
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<td>- Spinal Neurostimulators</td>
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<td>- Deep Brain Stimulators</td>
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<td>- Neuromuscular Stimulators</td>
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<tr>
<td>- Vagal Nerve Stimulators for Epilepsy</td>
<td>- Vagal Nerve Stimulators for Epilepsy</td>
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<td>- Surgical Treatment of Morbid Obesity</td>
<td>- Surgical Treatment of Morbid Obesity</td>
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<td>- Surgical Treatment of Sleep Apnea</td>
<td>- Surgical Treatment of Sleep Apnea</td>
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<td>- Temporomandibular Joint Surgery</td>
<td>- Temporomandibular Joint Surgery</td>
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<td>- Transplants, Bone Marrow and Organ</td>
<td>- Transplants, Bone Marrow and Organ</td>
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<tr>
<td>- Varicose Vein Treatment</td>
<td>- Varicose Vein Treatment</td>
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<tr>
<td>- Vertebroplasty and Kyphoplasty, Percutaneous</td>
<td>- Vertebroplasty and Kyphoplasty, Percutaneous</td>
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<tr>
<td><strong>Transportation (non-emergency)</strong></td>
<td><strong>Transportation (non-emergency)</strong></td>
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Effective: 1/1/2010

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. PARTNERS is a Medicare Advantage organization with a Medicare contract to provide HMO and PPO plans. Plans are administered by BCBSNC. Blue Cross and Blue Shield of North Carolina and PARTNERS are independent licensees of the Blue Cross and Blue Shield Association.
Request for approval of cataract extraction with intraocular lens implantation

Prior Authorization Guidelines require that authorization be obtained from Healthcare Services prior to certain surgical procedures, including extracapsular cataract extraction with intraocular lens.

To assist providers with obtaining prior approval for cataract surgery, we have developed the request form shown on the next page. This form has been developed to simplify the collection and submission of necessary data.

Our goal is to expedite the process for you and your office staff. Please share the form with those individuals in your office who are involved with the prior approval processes.

Completed forms can be faxed to Healthcare Services at 1-336-794-1556.

Additional copies of the form can be printed from our Web site at bcbsnc.com/content/providers/bluemedicare-providers/resources-and-forms/index.htm.

Continued on page 7
Request for approval of cataract extraction  (Continued from page 6)

Blue Medicare HMO™  Blue Medicare PPO™  

Request for Approval of  
Cataract Extraction with Intraocular Lens Implantation

Member’s name: ____________________________________________

BlueMedicare ID#  J  DOB: ________________________________

CPT code ______  Surgical site:  Right  □  Left  □  Surgery date: __________

Facility name: ___________________________  Facility provider number: ___________________________.

Physician name: ___________________________  Physician provider number: ___________________________.

Visual complaints: ____________________________________________

Best-corrected visual acuity, based on a recent manifest refraction:

<table>
<thead>
<tr>
<th>SPH</th>
<th>CYL</th>
<th>AXIS</th>
<th>ACUITY</th>
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</table>

If acuity is better than 20/50, include glare test results (low or medium setting): ____________________________

Type of cataract:  Nuclear  □  Cortical  □  PSC  □  ASC  □  Clefts / Vacuoles  □

List any other ocular conditions: ____________________________________________

Any effect on visual acuity?  
(if yes, please attach clinical documentation)

Yes  □  No  □

Yes  □  No  □

Is surgery expected to improve vision?  Yes  □  No  □

Is cataract removal needed for visualization of the fundus?  Yes  □  No  □

If yes, why? ____________________________________________

Any lens-induced glaucoma or inflammation present?  Yes  □  No  □

Has the patient had cataract surgery in the fellow eye?  Yes  □  No  □  Date: __________

Please submit request to:  
Blue Medicare HMO / PPO  
Fax: (336) 794-1556  
Telephone:  1-888-296-9790

Sender’s name: ____________________________  Sender’s phone #: ____________________________

Origination date: 10/1/06  Revision: Approved by PARTNERS Healthcare Services Medical Management 12/07/2006, 08/02/2007, 07/07/2009

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, Blue Cross and Blue Shield of North Carolina and PARTNERS are independent licensees of the Blue Cross and Blue Shield Association. ©, ™ Marks of the Blue Cross and Blue Shield Association.
Find the most up-to-date information from our centralized “Blue” Web site

Information about Blue Medicare HMO℠ and Blue Medicare PPO℠ is readily available on the Web. Publishing on the Web helps us to ensure that the information you receive about Blue Medicare HMO and Blue Medicare PPO is the most current and accurate information available. Use our Web site to find information about prior plan approval, health care coverage options and benefits, medication formularies, network providers, provider newsletters, manuals and more!

You can find us at the BCBSNC Web site at bcbsnc.com for “providers,” along with the answers to your Blue Medicare HMO and Blue Medicare PPO questions.
Member rights and responsibilities

We feel that it is important for you to be aware of the member rights and responsibilities that we share with our members. The following information outlines our expectations regarding how our members should interact not only with us – their health plan – but also with you, their provider of health care services, and in turn, how we should interact with them.

Member rights and responsibilities

Medicare beneficiaries have certain rights to help protect them. This information explains the rights and protections members receive as members of Blue Medicare HMO® or Blue Medicare PPO®.

Members have a right to be treated with fairness and respect

Members have the right to be treated with dignity, fairness and respect at all times. BCBSNC must obey laws against discrimination that protect members from unfair treatment. These laws say that we cannot discriminate against a member because of race or color, age, religion, national origin or any mental or physical disability you may have. If members think they have been treated unfairly due to their race, color, national origin, disability, age or religion, they should let us know. They can also contact the Office for Civil Rights in their area.

Members have a right to the privacy of their medical records and personal health information

There are Federal and State laws that protect the privacy of member medical records and personal health information. We keep member personal health information private as protected under these laws. Any personal health information that a member gives us when they enroll in this plan is protected. We will make sure that unauthorized people do not see or change member records. Generally, we must get written permission from the member (or from someone the member has given legal power to make decisions for them) before we can give their health information to anyone who is not providing their care or paying for their care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. The laws that protect member privacy give members rights related to getting information and controlling how their health information is used. Blue Medicare HMO and Blue Medicare PPO are required to provide members with a notice that tells about these rights and explains how we protect the privacy of member health information. For example, members have the right to look at their medical records and to get a copy of the records (there may be a fee charged for making copies). Members also have the right to ask for additions or corrections to their medical records (if members ask Blue Medicare HMO and Blue Medicare PPO to do this, we will review the request and determine whether the changes are appropriate). Members have the right to know how their health information has been given out and used for non-routine purposes. If they have questions or concerns about the privacy of their personal health information and medical records, they can call Blue Medicare HMO at 1-888-310-4110 or Blue Medicare PPO at 1-877-494-7647.

Members have the right to get their prescriptions filled within a reasonable period of time

Members should get all of their prescriptions filled from a network pharmacy – that is, from pharmacies that contract with Blue Medicare HMO or Blue Medicare PPO. Members have the right to go to any network pharmacy in order to get their prescriptions filled at the benefit level. Members have the right to timely access to their prescriptions.

Regional Office for Civil Rights

<table>
<thead>
<tr>
<th>States included in region:</th>
<th>Phone number:</th>
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<tbody>
<tr>
<td>North Carolina</td>
<td>1-404-562-7886</td>
</tr>
<tr>
<td>Alabama</td>
<td>1-404-331-2867 (TTY/TTD)</td>
</tr>
<tr>
<td>Florida</td>
<td>For the hearing and speech impaired:</td>
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<tr>
<td>Georgia</td>
<td>Address:</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Office for Civil Rights</td>
</tr>
<tr>
<td>Mississippi</td>
<td>U.S. Department of Health</td>
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<tr>
<td>South Carolina</td>
<td>and Human Services</td>
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<tr>
<td>Tennessee</td>
<td>Human Services</td>
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</table>

Address:
Atlanta Federal Center Suite 3B
7061 Forsyth Street, S.W.
Atlanta, GA 30303-8909

Continued on page 10
“Timely access” means that they can get their prescriptions filled within a reasonable amount of time.

**Members have the right to know their treatment choices and participate in decisions about their health care**

Members have the right to know about the different Medication Therapy Management Programs offered and in which they may participate. Members have the right to be told about any risks involved in their care. Members have the right to refuse treatment. This includes the right to stop taking their medication. If members refuse treatment, they accept responsibility for what happens as a result of refusing treatment. Members have the right to get a detailed explanation from Blue Medicare HMO and Blue Medicare PPO if they believe that a network pharmacy has denied coverage for a drug that they believe they are entitled to get or care they believe they should continue to receive.

**Members have the right to make complaints**

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the two different types of complaints members can make. Which one members make depends on their situation. If members make a complaint, we must treat them fairly (i.e., not discriminate against them). Members have the right to get a summary of information about the appeals and grievances that have been filed against these plans in the past. To get this information, members can call Blue Medicare HMO at 1-888-310-4110 or Blue Medicare PPO at 1-877-494-7647.

**Members have the right to get information about drug coverage and costs**

The BCBSNC Web site can tell members what they have to pay for prescription drugs under Blue Medicare HMO or Blue Medicare PPO. If members need more information, they can call Blue Medicare HMO at 1-888-310-4110 or Blue Medicare PPO at 1-877-494-7647. Members have the right to an explanation from us about any bills they may get for drugs not covered by their plan. We must tell members in writing why we will not pay for a drug, and how they can file an appeal to ask us to change this decision.

**Members have the right to get information about our plan and our network pharmacies**

Members have the right to get information from us about Blue Medicare HMO or Blue Medicare PPO and our Medicare Advantage prescription drug plans. This includes information about our financial condition and about our network pharmacies. To get any of this information, members can call Blue Medicare HMO at 1-888-310-4110 or Blue Medicare PPO at 1-877-494-7647.

**Members have the right to disenroll from their plan**

Members have the right to disenroll from Blue Medicare HMO and Blue Medicare PPO plans with Medicare prescription drug benefits during certain periods by giving written notice to the plan of their intent to do so. Coverage will end on the last day of the month following the date when Blue Medicare HMO or Blue Medicare PPO receives the written request. To end coverage, members may send written notice to:

Blue Medicare HMO or
Blue Medicare PPO
P.O. Box 17468
Winston-Salem, NC 27116

Members will receive an acknowledgement of disenrollment from Blue Medicare HMO or Blue Medicare PPO.

**How to get more information about member rights**

Anyone with questions or concerns about member rights and protections, can call Blue Medicare HMO at 1-888-310-4110 or Blue Medicare PPO at 1-877-494-7647. Free help and information is also available from Seniors’ Health Insurance Information Program (SHIIP). SHIIP can be reached at 1-800-443-9354. In addition, the Medicare program has written a booklet called “Your Medicare Rights and Protections.” To get a free copy, call 1-800-MEDICARE (1-800-633-4227). For the hearing and speech impaired, call 1-877-486-2048 (TTY/TDD). Members can call 24 hours a day, 7 days a week. Or, they
Member rights and responsibilities  (Continued from page 10)

can visit www.medicare.gov to order this booklet or print it directly from their computer.

What members can do if they think they have been treated unfairly or their rights are not being respected.

For concerns or problems related to member Medicare rights and protections described in this section, members can call Blue Medicare HMO at 1-888-310-4110 or Blue Medicare PPO at 1-877-494-7647. Members can also get help from SHIIP by calling 1-800-443-9354.

Member responsibilities under Blue Medicare HMO or Blue Medicare PPO

Along with the rights members have under Blue Medicare HMO or Blue Medicare PPO, members also have some responsibilities. Member responsibilities include doing the following:

- Becoming familiar with their coverage and the rules they must follow to get care as a member. Members should use the information available on the BCBSNC Web site as well as other information available about their coverage, what they have to pay, and the rules they need to follow. Members can call Blue Medicare HMO at 1-888-310-4110 or Blue Medicare PPO at 1-877-494-7647 if they have any questions.

- Giving their health care provider(s) the information their providers need to care for the member, and members should follow the treatment plans and instructions given to them. Members should ask their health care provider(s) if they have any questions.

- Paying their plan premiums and any copayments they may owe for the covered drugs they get.

Members should let Blue Medicare HMO or Blue Medicare PPO know if they have any questions, concerns, problems or suggestions. If they do, they can call Blue Medicare HMO at 1-888-310-4110 or Blue Medicare PPO at 1-877-494-7647.
Your provider data

Addresses, phone numbers and a current list of all providers at your facility/practice are routinely made available to Blue Medicare HMO® and Blue Medicare PPO® members via our online provider directories so that members can quickly locate you and schedule appointments. Having accurate mailing information on file for your practice also ensures that you receive claim payments and other important correspondence in a timely manner from us. Our ability to successfully direct members to you for their medical care depends on the accuracy of the information that we have on file for your facility/practice.

To ensure that we provide our members with the most current information related to your practice, please report any practice-related changes to your regional Network Management field representative or complete and return a provider Demographic Form, which can be found on the “Provider” page on our Web site at bcbsh.com/assets/providers/public/pdfs/Provider_Update.pdf

When using the online form be sure to respond to the email address link listed as MParkBIU@bcbsnc.com, located on the lower portion of the form.

Network Management should be notified whenever there’s a change of ownership, name and/or tax identification to your health care organization. In addition, Network Management should be notified about any opening, closing, and/or relocation of a practice site. Changes in services may also require Network Management to be notified — for example a home health agency adding home infusion therapy services. If in doubt — please call us!

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®
- YPF – Blue Medicare PPO®

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 – alpha prefix YPW lets you know that the member’s coverage type is an HMO plan. If you see YPF, you’ll know the coverage type is PPO.

By using the member’s alpha prefix, you can tell at a glance if a member has an HMO or PPO plan. 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.

Please note that Reynolds American Inc. retirees previously were enrolled in a unique HMO plan and maintained the customized alpha prefix of YPJ. However, as of January 1, 2009, Reynolds American Inc. retirees became eligible for benefits through the Blue Medicare HMO plan, and we retired the customized prefix of YPJ.
Blue Medicare HMO and Blue Medicare PPO member ID cards are readily recognizable, but remember that the cards include both BCBSNC and PARTNERS information. It’s important that you review the cards carefully and note the Blue Medicare alpha prefixes and PARTNERS health plan information. Don’t be confused by the Blue Cross and Blue Shield Association symbols and BCBSNC written text. Always remember that Blue Medicare is offered by PARTNERS National Health Plans of North Carolina, Inc., a BCBSNC company. Because of this, the following basic rules apply:

- Only providers directly contracted with PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS) are considered in network for Blue Medicare HMO and Blue Medicare PPO.
- Providers participating with PARTNERS to provide services to Blue Medicare HMO and/or Blue Medicare PPO members are not eligible to see members enrolled in BCBSNC commercial products as in network unless contracted with Blue Cross and Blue Shield of North Carolina.
- Providers participating with both PARTNERS and BCBSNC cannot use Blue eSM electronic transactions for Blue Medicare HMO and PPO claims and/or member information.
- Claims submitted to BCBSNC for Blue Medicare HMO and PPO members in error will be returned to the submitting provider or electronic clearinghouse. This includes both paper and electronic claims.

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<table>
<thead>
<tr>
<th>Blue Medicare HMO™ Standards</th>
</tr>
</thead>
</table>
| The plan is offered by PARTNERS National Health Plans of North Carolina, Inc., a BCBSNC Company |<John Doe>

Member ID
<YPWJ12345678-01>

<table>
<thead>
<tr>
<th>Group No</th>
<th>Effect Date</th>
<th>Rx Expiration</th>
<th>Rx Formulary</th>
<th>Rx Group</th>
<th>Issuer</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3&gt;</td>
<td>&lt;01/01/06&gt;</td>
<td>&lt;12/31/08&gt;</td>
<td>&lt;123456&gt;</td>
<td>&lt;ABCDEF&gt;</td>
<td>&lt;123456&gt;</td>
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</tbody>
</table>

Contract # H3449 013

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<table>
<thead>
<tr>
<th>Blue Medicare HMO</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare R</td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Coverage</td>
<td></td>
</tr>
</tbody>
</table>

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**Important reminders about Blue Medicare HMO and Blue Medicare PPO**

Visit the provider's page at bcbsnc.com/providers | page 13
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.

<table>
<thead>
<tr>
<th>Five useful Spanish health phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soy el doctor (male) / Soy la doctora (female)</td>
</tr>
<tr>
<td>Cómo se siente hoy?</td>
</tr>
<tr>
<td>Dónde le duele?</td>
</tr>
<tr>
<td>Qué medicina o remedios caseros está tomando?</td>
</tr>
<tr>
<td>Su próxima cita es ...</td>
</tr>
</tbody>
</table>

PARTNERS, together with HealthTrioconnect, utilizes the power of the Internet to deliver a comprehensive suite of administrative transactions — all with secure messaging to enable HIPAA-compliant communication. HealthTrioconnect allows you to easily perform the following 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

HealthTrioconnect streamlines many office management tasks that have traditionally been done manually or by phone. To find out more about HealthTrioconnect 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 at 1-888-296-9790.

Important message for providers who participate with BCBSNC and utilize Blue eSM

HealthTrioconnect 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 cannot conduct transactions for Blue Medicare HMOSM or Blue Medicare PPOSM products. Claims activity for Blue Medicare HMO and Blue Medicare PPO by use of Blue e will be rejected by the Blue e system.
### 2010 Blue Medicare HMO℠ and Blue Medicare PPO℠ Benefit Comparison

<table>
<thead>
<tr>
<th>Provider choice</th>
<th>Blue Medicare HMO</th>
<th>Blue Medicare PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced plan</td>
<td>Medical-only plan</td>
<td>Standard plan</td>
</tr>
<tr>
<td>Provider choice</td>
<td>In-network benefits only Must use a network provider</td>
<td>In-network benefits only Must use a network provider</td>
</tr>
<tr>
<td>Choose any network or out-of-network physician at the same cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary care physician office visits</th>
<th>$15 copayment for in-network visits only</th>
<th>$5 copayment for in-network visits only</th>
<th>$25 copayment for in-network visits only</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network benefits only</td>
<td>$20 copayment for in-network visits</td>
<td>$20 copayment for in-network visits</td>
<td>$20 copayment for in-network visits</td>
</tr>
<tr>
<td>Pay 20% coinsurance for out-of-network visits</td>
<td>$40 copayment for out-of-network visits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient hospital benefits</th>
<th>$550 copayment for each Medicare-covered stay</th>
<th>$350 copayment for each Medicare-covered stay</th>
<th>$975 copayment for each Medicare-covered stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$700 copayment for each Medicare-covered stay</td>
<td>$700 copayment for each Medicare-covered stay</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Medicare prescription drug benefit | Includes our enhanced drug benefit No deductible Generics covered in coverage gap | None | Includes standard drug benefit No deductible No coverage in the coverage gap |
|----------------------------------|---------------------------------------------|------|---------------------------------------------|---------------------------------------------|
| Includes our enhanced drug benefit No deductible Generics covered in coverage gap | Includes our enhanced drug benefit No deductible Generics covered in coverage gap |

<table>
<thead>
<tr>
<th>Features</th>
<th>Includes our most robust medical benefits Prescription drug coverage offered</th>
<th>Includes our most robust medical benefits</th>
<th>Basic medical and standard prescription drug coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freedom to visit out-of-network providers</td>
<td>Freedom to visit out-of-network providers at generally the same benefit level as in-network providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For additional information about Blue Medicare HMO and Blue Medicare PPO benefit plans, including summary of benefits, exclusions and limitations, please visit us on the Web at: **bcbsnc.com/medicare.**

Benefits, premium and/or copayment/coinsurance may change on January 1, 2011.

The Federal government established limits on when and how often Medicare beneficiaries may enroll in or change Medicare Advantage and Medicare prescription drug plans. For more information on these enrollment regulations, call us at **1-800-665-8037** (TTY/TDD: **1-888-451-9957**), 7 days a week, 8 a.m. – 8 p.m.

Providers are reminded that benefits and eligibility should be verified in advance of providing services.
Effective January 1, 2010: Medicare Advantage PPO Network Sharing available for out-of-state Blue Cross and Blue Shield members

Beginning January 1, 2010, all Blue Medicare Advantage (MA) PPO Plans, including the PARTNERSSM-offered Blue Medicare PPOSM plan, will participate in network sharing. This network sharing will allow all Blue Cross and Blue Shield (BCBS) MA PPO members from another state to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO Plan, as long as the member sees a contracted BCBS MA PPO provider.

This means that, as a provider participating in the Blue Medicare PPOSM plan, you will be able to see Blue MA PPO members from out-of-state Blue Plans. These members are eligible to receive their same in-network level of benefits – just like when receiving care from their Blue Plan’s in-network providers at home.

Blue MA PPO network sharing extends the same access of care to MA PPO out-of-state Blue Plan members when receiving care in North Carolina that’s available to Blue Medicare PPO members. Claims for services will be reimbursed in accordance with your Blue Medicare PPO negotiated rate with PARTNERS National Health Plans of North Carolina, Inc.

Providers who are not participating in the Blue Medicare PPO plan are not eligible to see Blue MA PPO out-of-state members as “in-network.” Non-participating providers will receive the Medicare-allowed amount for covered services, except for Urgent or Emergency care. Urgent or Emergency care will be reimbursed at the member’s in-network benefit level.

All other services will be reimbursed at the member’s out-of-network benefit (when out-of-network benefits are available) for non-participating providers.

How to recognize members from out-of-state Blue Plans participating in Blue MA PPO network sharing

The “MA” in the suitcase logo on a member’s identification card tells you that the card belongs to a member who is eligible as part of the Blue MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their BCBS member identification cards.

MA PPO logo shown here:

Providers are reminded that a person’s possession of an identification card is not a guarantee of not a guarantee of enrollment, benefits or eligibility in a Blue MA PPO plan. A member’s identification, enrollment, benefits and eligibility should always be verified in advance of providing services, except when verification is delayed because of Urgent or Emergency situations.

Verification is easy!

Verifying benefits and eligibility for Blue MA PPO out-of-state members is easy! Just call BlueCardSM Eligibility at 1-800-676-BLUE (2583) and provide the member’s alpha prefix information, located on their Blue Plan-issued membership ID card. Blue Medicare PPO providers who also participate with BCBSNC have the added convenience of being able to use Blue eSM to submit electronic eligibility requests for out-of-state Blue Plan members.

Claims administration for out-of-area MA PPO Blue Plan members

Network sharing for MA PPO out-of-state Blue Plan members makes claims filing simple. After providing services to eligible members, submit claims to BCBSNC – right here in North Carolina.

Beginning January 1, 2010, submit electronic claims to BCBSNC under your current BCBSNC billing practices or enroll for electronic claims filing with BCBSNC. Contact BCBSNC to set up electronic billing by visiting the Electronic Solutions page of the BCBSNC Web site located at: bcbsnc.com/content/providers/edi/index.htm. If still filing claims using paper claim forms, send claims for MA PPO out-of-state Blue Plan members to:

BCBSNC
P.O. Box 35
Durham, NC 27702

Important! Claims for services provided to MA PPO out-of-state Blue Plan members should be sent to BCBSNC. Medicare should not be billed directly.

Continued on page 17
Claims payment for services provided to MA PPO out-of-state Blue Plan members will be based on your contracted Blue Medicare PPO rate. Once you submit an MA PPO claim to BCBSNC, the claim will be forwarded to the member’s Blue Plan for benefits processing. BCBSNC will work with the member’s out-of-state Blue Plan to determine eligible benefits and then send the payment directly to you.

MA PPO out-of-state Blue Plan members who see Blue Medicare PPO participating providers will pay in-network cost sharing (in-network copayments, coinsurance and deductibles). Providers may collect any applicable copayment amounts from the member at the time of service. Additionally, providers may collect from members any deductible and/or coinsurance amounts as reflected on the payment remittance for a processed claim (members may not be balance billed for any additional amounts). After January 1, 2010, if you have questions about a processed claim for a Blue MA PPO out-of-area member, call BCBSNC BlueCard® Customer Service for assistance at 1-800-487-5522.

If you have any questions regarding the MA PPO network sharing program for out-of-area Blue Plan members, please contact your local Network Management representative.

Please note that providers participating with PARTNERS National Health Plans of North Carolina, Inc., who are already servicing MA members enrolled in the Blue Medicare PPO℠ plan are required to provide services to out-of-area, Blue Plan-eligible MA PPO members seeking care within North Carolina.

The same contractual arrangements apply to MA PPO out-of-area Blue Plan members as with our local Blue Medicare PPO members.

Note: If your practice is currently full (or becomes full) and is closed to all new Medicare Advantage PPO members, you are not required to provide services for MA PPO out-of-area Blue Plan members.

Reminder for Hospitals: POA Indicators Required

The Centers for Medicare & Medicaid Services (CMS) requires completion of the Present On Admission (POA) indicator for every diagnosis on an inpatient acute care hospital claim. Hospitals providing care for Blue Medicare HMO℠ and Blue Medicare PPO℠ members are required to follow CMS’ POA reporting guidelines when submitting claims for services provided to our members.

For inpatient acute care prospective payment system (PPS) discharges on or after October 1, 2008, certain diagnosis codes on claims could trigger a higher paying DRG (diagnosis related groups) at the time of discharge (but not at the time of admission). The DRG that must be assigned to the claim will be the one that does not result in the higher payment.

Effective for discharges on or after October 1, 2008, Blue Medicare HMO and Blue Medicare PPO and Medicare Supplemental products should apply CMS POA adjudication logic. Providers will not be compensated for those services that are non-reimbursable as identified in CMS’ Hospital-Acquired Conditions and Present On Admission Indicator Reporting program, or successor program(s), in accordance with CMS payment policies.

Attention Dialysis Providers

Reminder: The in-home hemodialysis inclusive rate per treatment is the same as the in-center hemodialysis inclusive rate per treatment.
Notice of Amendment to Agreement with PARTNERS National Health Plans of North Carolina, Inc.

As you know, federal legislation has made numerous changes to the Medicare program. Your current Agreement in the section entitled “Hold Harmless” incorporates certain CMS-required provisions regarding the protection of members. Changes to CMS’ requirements that will be effective January 1, 2010 result in our obligation to amend our contracts to incorporate specific Hold Harmless provisions as they relate to members that are dually eligible for both Medicare and Medicaid.

Accordingly, pursuant to the amendment provision of your Agreement, we are providing you notice of amendment to your Agreement that will be effective January 1, 2010. The amendment is as follows:

The Section entitled “Hold Harmless” is hereby amended to include the following:

Members eligible for Medicaid. Providers agree that members eligible for both Medicare and Medicaid (“Dual Eligibles”) will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Provider agrees to accept the MA plan payment as payment in full or bill the appropriate state Medicaid agency for such amounts.

Please contact your local Network Management regional representative with any additional questions. Thank you very much for your continued care and service to Blue Medicare Members.

Diagnostic Imaging Management (DIM) coming soon for Medicare Advantage

We think that it’s important that you know that we’ll be expanding the BCBSNC Diagnostic Imaging Management Program in mid-2010 to include members covered by the Medicare Advantage plans: Blue Medicare PPO and Blue Medicare HMO. We’re committed to making the authorization process for these members as similar as possible to that of the BCBSNC members who are already utilizing the program administered by BCBSNC’s vendor American Imaging Management (AIM). We will send providers an official notice of the extension of this program to Blue Medicare PPO and Blue Medicare HMO members, along with additional details about the program and its authorization process, at least ninety days prior to the implementation date.
2010 Medicare Part-D Formulary Coverage Changes

For the upcoming plan year 2010, changes are being made to the Blue Medicare HMO™ and Blue Medicare PPO™ and BCBSNC's Blue Medicare Rx℠ Part-D formularies, including the administrative process regarding coverage of certain drugs. More information, including coverage review criteria and fax request forms, can be found at bcbsnc.com/medicare.

### Prior Review
Effective 1/1/2010, prior review will be required for the following drugs and drug classes:

<table>
<thead>
<tr>
<th>Preferred Medications</th>
<th>Non-preferred Medication* (Physician Certification Required as of January 1, 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proton Pump Inhibitors (PPIs)</strong></td>
<td><strong>Proton Pump Inhibitors (PPIs)</strong></td>
</tr>
<tr>
<td>Omeprazole (generic Prilosec®)</td>
<td>Aciphex®</td>
</tr>
<tr>
<td>Pantoprazole (generic Protonix®)</td>
<td>Kapidex™</td>
</tr>
<tr>
<td>Nexium®</td>
<td>Prevacid®</td>
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<tr>
<td></td>
<td>Protonix® packet for suspension</td>
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<tr>
<td></td>
<td>Zegerid®</td>
</tr>
<tr>
<td><strong>Intranasal Steroids</strong></td>
<td><strong>Intranasal Steroids</strong></td>
</tr>
<tr>
<td>Fluticasone (generic Flonase®)</td>
<td>Beconase AQ®</td>
</tr>
<tr>
<td>Flunisolide (generic Nasarel®)</td>
<td>Nasacort® AQ</td>
</tr>
<tr>
<td>Nasonex®</td>
<td>Rhinocort Aqua®</td>
</tr>
<tr>
<td></td>
<td>Veramyst®</td>
</tr>
<tr>
<td></td>
<td>Omnaris®</td>
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</tbody>
</table>

In order to request coverage for any of these drugs, providers must complete and fax a prior authorization request form to BCBSNC. Fax numbers are included on the forms which are located at bcbsnc.com/medicare.

### Step Therapy
Also effective 1/1/2010, coverage of non-preferred proton pump inhibitors and intranasal steroids will require step therapy. Going forward, reimbursement of non-preferred drugs in these categories will be considered only after a member's physician certifies in writing that the member has previously used a preferred proton pump inhibitor or intranasal steroid and such drug was ineffective in treating the condition or was detrimental to the member's health. Fax request forms can be found at bcbsnc.com/medicare.

### Quantity Limitations:
In addition, a number of drugs will have quantity limitations in plan year 2010. These quantity limits follow dosing guidelines for each drug approved by the Food and Drug Administration (FDA). The full list of drugs with quantity limitations can be found on bcbsnc.com/medicare.

If you have questions or need more information, please contact your regional Network Management representative.

*Only the non-preferred drugs listed are subject to physician certification requirement.*
CMS expedited appeals process when coverage ends for skilled nursing facilities, home health agencies or comprehensive outpatient rehabilitation facilities

Blue Medicare HMO members and Blue Medicare PPO members have the right to an expedited review by a quality improvement organization (QIO) when they disagree with a PARTNERS decision to end coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF). The Centers for Medicare & Medicaid Services (CMS) final ruling of April 2003 stated that skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must provide an advance Notice of Medicare non-coverage (NOMNC) to PARTNERS members no later than two days before coverage of their services will end. If patients do not agree that covered services should end, they may request an expedited review of the case by the QIO in their state. The Blue Medicare HMO and Blue Medicare PPO plan must furnish a detailed notice explaining why services are no longer necessary or covered.

Rule compliance
To ensure compliance with the April 2003 ruling, the PARTNERS policy and procedure is as follows:
- All contracting and non-contracting providers must ensure delivery of the notice to the member no later than two days/visits prior to the proposed termination of SNF, HHA or CORF services. They must also obtain the member’s or authorized representative’s signature on the NOMNC.
- The provider must place the original NOMNC in the member’s case file, provide a copy to the member and fax a copy of the notice to PARTNERS Healthcare Services Department at 1-336-659-2945.

How to appeal
Blue Medicare HMO and Blue Medicare PPO members have the right to an immediate review of the decision to end the coverage while services continue. The member must submit a timely request for immediate review directly to the QIO by noon of the day following receipt of the NOMNC. When the member receives the NOMNC more than two days/visits prior to the date that coverage is expected to end, the member may request an appeal to the QIO by noon of the day before coverage ends (effective date of notice).
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 patient 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.

Notification required for hospital admissions

Hospital admissions, both elective and urgent/emergent, require plan notification and medical necessity review. Hospitals are required to notify the plan and submit clinical information for a medical necessity review prior to an elective admission or within one business day of an urgent/emergent admission. Failure to notify the plan can result in a denial of service and claims nonpayment. Please remind your business office and utilization management department to notify PARTNERS Healthcare Services of these admissions by calling 1-888-296-9790.
eDispense™ Medicare Part-D vaccine manager

Participating providers have an easy online option to submit Medicare Part-D vaccine claims to Medco® – eDispense™.

eDispense Part-D Vaccine Manager, a product of Dispensing Solutions, Inc. (DSI), is a Web-based application, that offers a solution for the submission and adjudication of claims for physician-administered Part-D vaccines covered by member’s Medicare Part-D pharmacy benefits – vaccination claims that cannot be submitted on a standard CMS-1500 medical claim form.

eDispense makes real-time claims processing for in-office administered Medicare Part-D vaccines available through its secure online access.

Services offered with eDispense allow providers to quickly and electronically verify member’s Medicare Part-D vaccination coverage and submit claims to our pharmacy benefits manager Medco directly from your in-office Internet connection.

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

Enrollment is an easy two-step process

Step 1 – Select an authorized staff member who is most likely to be the primary user of the system to enroll the practice. This person should be prepared to provide the following information about the practice:

- Tax identification number
- National provider identifier (NPI)
- Medicare ID number
- Drug enforcement administration (DEA) number
- State medical license number

Step 2 – Go to Dispensing Solutions’ Web site and complete a simple one-time online enrollment application at enroll.edispense.com.

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

Provider enrollment in eDispense vaccine manager and eDispense facilitated transactions between Medco and providers is a voluntary option for providers. Medicare Part-D vaccine claims eligible for electronic processing with eDispense Part-D Vaccine Manager are reimbursed according to the Medco allowance, less member liability. PARTNERS offers network providers access to eDispense Vaccine Manager for Medicare Part-D transactions through our pharmacy benefits manager Medco Health Solutions, Inc., (Medco) by agreement between Medco and Dispensing Solutions, Inc. (DSI).

Office-administered vaccines eligible under a member’s Part-D pharmacy benefit are to be obtained from the administering health care provider. A member should never be requested to obtain a vaccine from a pharmacy for an in-office vaccination.
Power mobility devices reminder

CMS implemented a change to the coverage determination for Power Mobility Devices (PMD) – power wheelchairs (PWC) and power operated vehicles (POV) – as of April 1, 2008. The revision was in relationship to the statutory requirement that the treating physician must perform a functional assessment and a comprehensive physical exam to support the request for the PMD. The assessment should include, but not be limited to, any factors that would impact the members’ ability to participate in activities of daily living (ADL), such as; eating, grooming, dressing, bathing and toileting, and describe in what way a PMD would make a difference. The complete CMS policy for power mobility devices may be viewed at: www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=23613&lcd_version=22&show=all.

Additional documentation guidance for physicians by the Medical Directors at the four DME MAC Jurisdictions was published in October, 2008 and can be found at: www.cignagovernmentservices.com/jc/pubs/news/2008/1008/cope8682.pdf.

All documentation, including the comprehensive physical exam and office notes completed by the treating physician, should be sent to PARTNERS Healthcare Services for prior authorization of the PMD accompanied by the PWC/POV request form. A copy of the PWC/POV request form is located in the online Provider Manual, Chapter 10.3 Power Operated Vehicle/Motorized Wheelchair Requests and can be downloaded here: bcbsnc.com/assets/providers/public/pdfs/Provider_Manual.pdf.

New counties for Medicare Advantage plans

PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS), a fully owned subsidiary of Blue Cross and Blue Shield of North Carolina (BCBSNC), has expanded its Blue Medicare HMO™ and Blue Medicare PPO™ network to 19 additional North Carolina counties. These Medicare Advantage plans offer lower out-of-pocket costs and more benefits than traditional Medicare, including preventive care and routine vision care.

Employer groups were able to purchase the plans beginning August 1, 2009, while individuals can begin purchasing the plans starting November 15, 2009 for a January 1, 2010 effective date. Many health care providers in the new counties already accept the plans, and the network of providers continues to grow statewide.

The newly approved counties are:

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.

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 do not discriminate based on color, gender, religion, national origin, age, race, disability, handicap, sexual orientation, genetic information, source of payment or health status as defined by the Centers for Medicare & Medicaid Services (CMS). All qualified Medicare beneficiaries may apply. BCBSNC and PARTNERS are independent licensees of the Blue Cross and Blue Shield Association.