State Health Indemnity Plan moves to PPO

Effective July 1, 2008 – State Health Indemnity Members transitioned to NC SmartChoice PPO

As mentioned in the winter 2007–2008 edition of Blue Link, the State Health Indemnity Plan was no longer available as of July 1, 2008. The closure of the Indemnity plan came as a result of 2007 legislation that afforded to the State’s Indemnity members the same choice of benefits and broad network access that members already enrolled in NC SmartChoice PPO plans receive.

During this year’s North Carolina State Health Plan annual enrollment, members were given the opportunity to choose one of the three NC SmartChoice PPO (preferred provider organization) plan options – the same NC SmartChoice PPO plan options, with which Blue Options® PPO participating providers are already familiar. Members, their dependents and retirees enrolled in the Indemnity Plan who did not make a selection were enrolled automatically in the PPO Standard Plan.

Effective July 1, 2008, all State Health Plan membership is now PPO membership. Always ask for the patient’s most recent ID card and be sure to update your records, replacing the patient’s previous State Health Indemnity information with their new NC SmartChoice PPO plan information.

Your help is needed to smoothly transition Indemnity Plan members to the SmartChoice PPO plans and keep claims payments timely and efficient. At each and every patient encounter, be sure to obtain a copy of the member’s most current SmartChoice PPO ID card. By doing this, claims can be reported with the member’s up-to-date information, and there will be no delay due to outdated information that may hinder the claims adjudication process. Also, after July 1, 2008, it is important to send all claims to the correct claims mailing address if not sending electronically.

Correct mailing address for State Health Plan PPO member’s claims:

BCBSNC
P.O. Box 30087
Durham, NC 27702

Providers can submit Indemnity Plan claims (for services provided prior to July 1, 2008) for up to 18 months, to:

Indemnity Plan mailing address:

NC Teachers and State Employees
Indemnity Plan
P.O. Box 30025
Durham, NC 27702

(Not to be used for claims with dates of service after June 30, 2008)

Indemnity Plan members and providers will still have access to Indemnity Plan Customer Service for questions about services provided prior to July 1, 2008. Members and providers will also have appeal rights after July 1, 2008, for services received by June 30, 2008.

(continued on page 2)
ValueOptions Medical Necessity Criteria available for State Health Plan PPO members

ValueOptions Medical Necessity Criteria were recently reviewed and approved by the ValueOptions Executive Medical Management Committee for distribution and use by all providers treating members managed by the organization. These criteria are available on the following Web site: valueoptions.com/providers/Handbook.htm.

ValueOptions Medical Necessity Criteria:

ValueOptions utilizes internally developed behavioral health clinical criteria to review care for adults and children/adolescents with mental health issues. The criteria are assessed and, if necessary, revised at least annually by the ValueOptions Corporate Executive Medical Management Committee. The criteria are available for your review at the following Web site: valueoptions.com/providers/Handbook.htm.

ValueOptions follows the criteria developed by the American Society of Addiction Medicine (ASAM) for treating adults and children/adolescents with substance abuse issues. If you do not already have a copy of the ASAM Criteria, it can be ordered from the following Web site: asam.org/ppc/ppc2.htm or by calling ASAM at 1-800-844-8948.

State Health Indemnity Plan moves to PPO
(continued from page 1)

By transitioning the State Health Plan membership into the PPO plan choices and closing the Indemnity Plan, arranging services and administering care for State Health Plan members becomes a more uniform process, which helps to reduce administrative duties and their associated cost for Blue Cross and Blue Shield of North Carolina (BCBSNC) PPO participating providers. However, if you are part of a health care business that is Cost Wise-participating but not participating in the Blue Options PPO network, your business is considered out-of-network (unless approved for continuity of care*) for State Health Plan members effective July 1, 2008, and member’s costs are higher for out-of-network services. If your health care business is not participating in the Blue Options PPO network, please contact your local network management office to find out about becoming an in-network provider.

*Continuity of care allows members, under certain conditions, to continue to receive care from an out-of-network provider at their in-network benefit level. Services must be authorized in advance by BCBSNC as prior approved and are limited to members; that have a chronic illness or condition, or are terminally ill, or in their second or third trimester of pregnancy or completing postpartum care.
New tobacco cessation E & M codes

Two new Evaluation and Management (E&M) codes – 99406 & 99407 – became effective on January 1, 2008. BCBSNC, including the North Carolina State Health PPO plan, is allowing reimbursement for these codes to support physicians and other health care providers with counseling patients about tobacco cessation. These codes are payable in addition to other E&M services provided on the same day.

The codes should be used to report services provided face to face by a physician or other qualified health care professional using “standardized, evidence-based screening instruments and tools with reliable documentation and appropriate sensitivity.” The choice of code depends on the time spent with the patient. Code 99406 should be used to report an intermediate visit (3-10 minutes), and code 99407 should be reported for an intensive visit (greater than 10 minutes).

A recent report showed that although a health care provider’s recommendation to quit smoking is a strong motivator, only one in three smokers is offered help to quit smoking by their doctor\(^1\). To help with these conversations, the following resources are available free of charge:

**QuitlineNC**

Refer BCBSNC and SHP PPO patients to the free QuitlineNC using a fax referral form or by suggesting that patients call 1-800-Quit-Now (1-800-784-8669). QuitlineNC is available in multiple languages, seven days a week from 8 a.m. until midnight. Callers can talk with a quit coach for a single counseling call or start a four-call program to guide tobacco-users through quitting.

QuitlineNC is jointly funded by the NC Health and Wellness Trust Fund and the NC Department of Health and Human Services.

**Provider toolkit on tobacco cessation counseling (in English and Spanish)**

The provider tobacco cessation toolkit contains materials to help providers build skills in counseling patients on tobacco cessation. The toolkit includes clinical guidelines for counseling, brochures to help start the conversation, fax referral forms for QuitlineNC, and other items. You can get a free toolkit by completing a fax order form. Questions about ordering toolkits can be directed to 1-800-218-5295.

**Member Health Partnerships\(^{SM}\)**

BCBSNC members can join the Member Health Partnerships program to work on quitting tobacco use, managing stress, losing weight and other health topics.\(^2,3\) The program includes materials and the opportunity to talk with a health coach. Providers can help members enroll by calling 1-800-218-5295. Members can also visit [bcbsnc.com](http://bcbsnc.com) to request an enrollment packet online.


2. Some employers have elected not to make the BCBSNC Member Health Partnerships programs available to their employees. Members should check with their benefit administrators to determine eligibility.

3. This service is not available to SHP members; however, the SHP offers other smoking cessation benefits. See [www.shpnc.org](http://www.shpnc.org) for more information.

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Credentialed and re-credentialed update

The BCBSNC Credentialing Committee recently updated the minimum liability insurance requirements for initial credentialing and re-credentialing of professional providers to raise the minimum to become more aligned with industry standards. The new minimum insurance liability limits are one-million dollars per occurrence / three-million dollars aggregate, over the previous one-million dollars per occurrence / one-million dollars aggregate. The limits increase went into effect May 1, 2008 for all new credentialing applications; the increase will become effective May 1, 2009 for all re-credentialing applications.
Inter-Plan Programs: Updates and reminders

Blue Cross of California changes names

On April 1, 2008, Blue Cross of California changed its operating name to Anthem Blue Cross. Additionally, California’s Blue Cross Life & Health subsidiary changed its name to Anthem Blue Cross Life and Health. Members of these health care plans are receiving new ID cards with the Anthem Blue Cross brand. However, for a period of several months, you may see both names if seeing these members (the name change will be completed by August 31, 2008).

Freightliner LLC Health Care Coverage

Effective in January 2008, Blue Cross Blue Shield (BCBS) began providing health care coverage for members of Freightliner LLC. Freightliner’s move to a national BCBS plan provides the same level of health care coverage for employees and dependents as before, with no change to deductibles, copayments and coinsurance amounts.

Please call the BCBS BlueCard® automated system at 1-800-676-2583 to obtain benefits and eligibility information for Freightliner members. You may also call this number for other out of state members receiving care in your office. Please refer to the following page for step-by-step instructions on using the automated eligibility and benefits system.

When you file claims for out of state members, please be sure to send them to BCBSNC. On the claim form, always indicate the member’s contract number, date of birth and three-character alpha prefix. For Freightliner members the alpha prefix for Preferred Provider Organization (PPO) members is FHN and the alpha prefix for Medicare PPO members is FET. This information can be found on the out of state member’s identification card.

Please contact your local Network Management field office if you need additional information or have questions around submitting claims or providing services for BCBS out of state members.

Drug utilization review programs for Wellmark members

Wellmark Blue Cross and Blue Shield, in cooperation with CatalystRx, conducts quarterly Drug utilization review (DUR) programs for Wellmark members. These programs primarily focus on patient safety. For example, they may identify members that have been prescribed a drug that has been recalled or identify members who are receiving multiple prescriptions from multiple providers and/or pharmacies. As a result of these programs, CatalystRx may contact the prescribing physician to make them aware of potential concerns for their patients. Communication with providers typically consists of an informational letter along with information on the patient in question. Because Wellmark Blue Cross and Blue Shield has members in North Carolina, as a courtesy, we wanted to make you aware of these programs in the event you received a mailing from CatalystRx.

BlueCard® program needs your feedback

Your feedback is important to help us make improvements in the Inter-Plan Programs processes and make your interactions with BlueCard a smooth and simple experience.

This year, you have an opportunity to tell us how we are doing via phone and/or online satisfaction survey. At any point throughout the year, you may receive a call on behalf of BCBSNC seeking input on your experience with servicing out-of-area members. Our research vendor may invite you to participate in online surveys and request your email address. If your office is contacted, we encourage you to participate in these surveys. We take your feedback seriously and incorporate into enhancements of our services to you.

• If you need information about the BlueCard program or have suggestions for improvements, please contact your regional Network Management representative or call BlueCard customer Service at 1-800-487-5522.

Thank you in advance for your participation. We appreciate your feedback.

Automatic crossover for all Medicare claims: All claims are being automatically submitted to the secondary payor. After your claim has been filed to Medicare – there’s no need for you to file a second claim to BCBSNC.

(Automatic crossover applies to both local BCBSNC claims and IPP BlueCard claims.)

Effective January 1, 2008, all Blue Plans now crossover Medicare claims for services covered under Medigap and Medicare Supplemental products, resulting in automatic claims submission of Medicare claims to the Blue secondary payor, and a reduction or elimination of the need for the provider’s office or billing service to submit an additional claim to the secondary carrier. Additionally, with all Blue Plans participating in this process, Medicare claims will crossover in the same manner nationwide. Whether the secondary payor is BCBSNC or another Blue’s Plan, you only need to file the claim once and the claim will be automatically routed for secondary processing.

(continued on page 5)
This new Medicare crossover process applies to all provider types, including: hospitals and facilities, professional providers, ancillary providers, federally qualified health centers, rural health clinics and comprehensive outpatient rehabilitation facilities. Federally qualified health centers, rural health clinics and comprehensive outpatient rehabilitation facilities can now bill Medicare using a UB-04 claim form without submitting a second CMS-1500 claim form to BCBSNC.

**How do I submit Medicare primary / Blue Plan secondary claims?**

For members with Medicare primary coverage and BCBSNC or another Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier. There is no need to submit a second claim to BCBSNC or another Blue Plan.

When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. Be sure to distinguish if the Plan is BCBSNC or a different Blue Plan. Check the member’s ID card for additional verification.

Be certain to include the alpha prefix as part of the member identification number. The members ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and crucial in facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to BCBSNC or another Blue Plan:

- If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to BCBSNC.

- If the remittance indicates that the claim was not crossed over, submit the claim to BCBSNC with the Medicare remittance information.

**When should I expect to receive payment?**

The claims you submit to the Medicare intermediary will be crossed over to BCBSNC or the out-of-state Blue Plan, only after they have been processed by the Medicare intermediary. This process may take up to 14 business days. This means that the Medicare intermediary will release the claim to BCBSNC or the out-of-state Blue Plan for processing at about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14 to 30 business days for you to receive payment from BCBSNC or the out-of-state Blue Plan.

**What should I do if I have not received a response to my initial claim submission?**

If you submitted the claim to the Medicare intermediary/carer, and have not received a response to your initial claim submission, do not automatically submit another claim. Rather, you should:

- Review the automated resubmission cycle on your claim system
- Wait 30 days
- Check claims status before resubmitting

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and can create confusion for the member.

**Questions?**

Answers to questions about claims that have crossed over can be found by accessing Blue e or by calling the Provider Blue Line at 1-800-214-4844 (for BlueCard claims call 1-800-487-5522). If you have general questions about the automatic crossover process, please contact your local Network Management field office.

**Medicare-related claims: Present on Admission indicator**

**Institutional billing**

Effective October 1, 2007, CMS requires hospitals to use a Present on Admission (POA) indicator for every diagnosis for all patients discharged on or after that date. It is one of the requirements of the Deficit Reduction Act of 2005 that the Secretary of Health and Human Services (HHS) identify a limited number of high-cost and/or high-volume conditions that are reasonably preventable through application of evidence-based guidelines, and pay at a lower rate when Medicare claims show these conditions as present only on discharge and not on admission.

Starting October 1, 2008, claims may be assigned a lower-paying DRG when one of the secondary diagnosis codes identified by CMS is present on discharge but not present on admission.

**What is the Present on Admission Indicator (POA)?**

The POA indicator is used to note a condition that is present at the time the order for inpatient admission occurs. It is noted by using one of the five values below that identify whether secondary diagnoses are present when the patient is admitted to a facility.

- Y = Yes
- U = No information in the record
- N = No
- W = Clinically undetermined

(continued on page 6)
Inter-Plan Programs: Updates and reminders
(continued from page 5)

1 = Used on 4010A1 and 5010 versions of the 837 to represent a space or a blank and means the Diagnosis Code is exempt from reporting POA.

Blank = Designates on the UB-04 Unreported/Not Used/Exempt from POA reporting.

Is the POA indicator required on all Medicare claims?
The POA indicator is required on all Medicare primary claims, paper and electronic, and all Medicare Advantage claims, paper and electronic. It is not required on Medicare secondary claims.

What are the diagnosis codes for which CMS requires a POA indicator to be reported?
The CMS Web page that reports the selected diagnoses can be accessed at: cms.hhs.gov/HospitalAcqCond/06_Hospital-Acquired%20Conditions.asp#TopOfPage.

Who should I contact with additional questions?
Information on the CMS Present on Admission requirement is available at: cms.hhs.gov/MLNMattersArticles/downloads/MM5499.pdf.

Improvements to the medical records process for out-of-area claims
Based on the feedback from providers like you, BlueCard has made improvements to the medical records process one of our top priorities. We now have a much more efficient process allowing us to send and receive medical records electronically among all Blue Cross and/or Blue Shield Plans around the country. This new method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims and eliminates lost or misrouted records. BCBSNC has embraced this new technology, and we are excited about related process improvements we expect to realize over the coming months. We also hope your office notices improvements to the efficiency of these processes.

Please continue to submit your medical records to BCBSNC when requested.

If you receive requests for medical records from other Blue Plans prior to rendering services, as part of the pre-authorization process, please submit them directly to the member's Plan that requested them.

Medicare Advantage claims: Steps to follow
Members who enroll in Medicare Advantage (MA) products may seek services out-of-network. Coverage rules are likely to vary by product type and MA plan. When you furnish services to an enrollee in a Medicare Advantage plan, please follow these steps:

1. Ask for the member ID card. Members have been asked not to show their standard Medicare card when receiving services; instead, members should provide their member ID. The Blue Cross and/or Blue Shield logo will be visible on the ID card along with one of the following logos that designate the type of health plan:

   Medicare Advantage PPO
   Medicare Advantage PFS
   Medicare Advantage MSA
   Medicare Advantage HMO
   Medicare Advantage POS

2. Verify eligibility by contacting 1-800-676-Blue (2583) and providing the alpha prefix. Be sure to ask if Medicare Advantage benefits apply. If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to BCBSNC. You can also inquire electronically using the 270/271 HIPAA eligibility transactions.

   For PFFS plans, you should review the Terms and Conditions by using the Web finder tool on the BCBSNC Web site at bcbsnc.com/providers/edi/pffs.cfm.

3. Submit claims to BCBSNC. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

Payment information
Once you submit Medicare Advantage claims, BCBSNC will send you the payment. In general, you may collect the co-payment amounts from the member at the time of service, but may not otherwise charge or balance bill the member. Special rules apply; however, for PFFS health plans where balance billing may be permitted under certain conditions.

PFFS payment information
In general, if you accept the Terms and Conditions and render services to a PFFS MA member, you are considered a deemed provider and will receive the Medicare payment rate for the covered services unless the PFFS plan has posted a higher payment rate in its terms and conditions. If you are a provider who accepts Medicare assignment and renders services to a Medicare Advantage member under a PFFS plan with whom you do not have a contract, you will be considered a non-contracted provider and will be reimbursed the Medicare payment rate for all covered services as well. If it is an emergency or if you did not have an opportunity to know the patient was a PFFS member you will be reimbursed the Medicare payment

(continued on page 7)
rate for all covered services as well. Providers should be certain they understand the applicable Medicare Advantage reimbursement rules. Please see the Terms and Conditions appropriate for the MA member for more details.

- Please make all claim status inquiries through BCBSNC.

- Please review the remittance notice concerning Medicare Advantage plan payment, member’s payment responsibility and balance billing limitations.

- If you have any questions, please contact BCBSNC.

Reminders for remittance notices:

Payment error rate measurement (PERM) in North Carolina

The Improper Payments Information Act of 2002 requires all federal agencies to review programs that are susceptible to errors in payments and eligibility determination. All Medicaid programs and State Children’s Health Insurance Programs (NC Health Choice) are subject to federal review under this law. In compliance with this act, the Centers for Medicare & Medicaid Services (CMS) implemented a national PERM program to measure improper payments in the Medicaid program and NC Health Choice. North Carolina has been selected as one of 17 states required to participate in PERM reviews for federal fiscal year 2007 (October 1, 2006 – September 30, 2007.) CMS is using three national contractors to measure improper payments in North Carolina’s Medicaid and NC Health Choice programs:

- The Lewin Group – to collect statistical data (claims)
- Livanta LLC – to collect medical policies and medical records
- HDI Incorporated – to review medical records

Livanta will contact providers directly to verify the correct name and address information and to determine how you want to receive the official requests for medical records (by facsimile or US mail.) Once you receive the request for medical records, the records must be submitted to Livanta, either electronically or in hard copy, within a timeframe indicated by Livanta. Providers are reminded of the requirement in Section 1902(a)(27) of the Social Security Act and Federal Regulation 42 CFR Part 431.107 to retain any records necessary to disclose the extent of services provided to individuals and to furnish information upon request regarding any payments claimed by the provider for rendering services.

It is critical for providers to cooperate and respond in a timely way to ensure that the North Carolina error rates are calculated properly. Please note that failure to respond to requests and/or insufficient documentation will be considered payment errors. A payment error can result in a payback by the provider and a monetary penalty for North Carolina.

ePrescribeSM – electronic prescribing

Electronic prescribing (ePrescribing) is an efficient, economical and secure way of using health care technology (e.g., computers or personal digital assistants) to improve prescription accuracy and patient safety while increasing the use of more cost-effective drugs by providing patient-specific drug information at the point of care. Through electronic prescribing, providers electronically gain secure access to patient information regarding health plan formularies, patient eligibility and medication history at the point of care. The result is a safer and efficient process that provides more accurate medication orders and less manual intervention, as patient prescriptions are sent electronically to the patient’s pharmacy of choice.

Advantages of using ePrescribing technology include:

- Streamlined provider prescribing process
- Clearer prescriptions, fewer calls and faxes to and from pharmacies asking for clarification on written scripts
- Ability to automate prescription refill authorizations
- Improve patient safety – ePrescribe will detect drug-drug interaction and provide information back to providers immediately

(continued on page 8)
Providers can access information about discounts and certified ePrescribe vendors at bcbnsnc.com/providers/eprescribe/. The BCBSNC Web site contain links to internet providers and certified vendors so prescribers can understand the options and opportunities that exist with certified, stand-alone ePrescribing applications and electronic medical record systems that have an embedded electronic prescribing capability. The initiative does not offer or promote a specific connectivity, software or hardware vendor.

To get started, go to bcbnsnc.com/providers/eprescribe/, where you can select a link to wireless or internet providers and links to certified ePrescribing solutions and take advantage of service discount offers.

We are improving our member’s ID cards

We have redesigned our member ID card as part of an overall Blue Cross and Blue Shield Association effort to standardize ID cards for all Blue members nationwide. The association wants to ensure that the benefit information on the cards is consistent, easy to find and understand.

Additionally, a North Carolina Senate bill, effective January 1, 2009, requires that all insurers list certain copayments on ID cards, as well as either the effective date of coverage or the issue date of the card.

What will change?

The main change is that the ID card will now be a more wallet-friendly, two-sided card instead of a four-sided card. As a result:

• Benefits displayed on the ID card will reflect the NCDOI-required copayment information and benefit information most commonly used at the time of service by providers and members.

• Benefits displayed will reflect the member’s responsibility (e.g., $0 or 20% coinsurance) rather than BCBSNC’s responsibility (e.g., 100% or 80%).

• If a member also has BCBSNC dental coverage, the Dental Blue® or Dental Blue for IndividualsSM logo will appear on the front of the ID card.

• Benefit information for routine vision, chiropractic care and mental health/substance abuse will no longer appear on the ID card.

• Helpful phone numbers and Web site addresses will be grouped together logically on the back of the ID card and will now have easy-to-understand descriptions.

What will not change?

Benefits will not change. The new member cards simply reflect a new look and the new requirements for information. As always, providers should verify member’s benefit information using Blue e or by calling the Provider Line at 1-800-214-4844, as the ID card is not a substitute for benefits information. In addition, since providers have told us that they value having the members names listed on the ID card for all dependents covered, as well as copayment amounts and helpful phone numbers, those items will continue to be noted on the new ID cards.

When will the ID cards be printed?

ID cards for our group business and under-65 individual business that are printed on or after September 15, 2008 will reflect the new design and card stock. This includes all new enrollees, requests for additional ID cards and group maintenance changes. Everyone will receive a new ID card at the time of their renewal.
Participating network physicians have contractually agreed to refer BCBSNC members to participating network providers for laboratory and other professional services. To confirm that a lab is participating, please refer to the following list or contact BCBSNC Customer Service for the most up-to-date information.

The following list of contracted reference laboratories are participating in all BCBSNC products as of June 1, 2008:

- ACA Laboratory
- Ameripath Consulting Pathology Services
- Carolina Medical Lab Group, Inc.
- Clinical Laboratory Services
- Coastal Carolina Pathology, PA
- Dianon System
- Dominion Diagnostics, LLC
- Fullerton Genetics Center
- Genzyme Genetics
- Greensboro Pathology Associates, PA
- Harris Histology Relief Service
- Horizon Laboratory Corp.
- Lab Corp. of America
- Liposcience, Inc.
- Meridian Laboratory Corporation
- Nextwave Diagnostic Laboratories
- Paladin Laboratories, LLC
- Pathologists Medical Lab
- Piedmont Pathology Associates
- Progressive Pathology, LLC
- Quest FKA SBCL
- Select Diagnostics, Inc.
- Skin Pathology Associates, PC
- Spectrum Laboratory Network
- US Labs
- Wilkesboro Clinical Lab
- Wilmington Pathology Associates

If you are currently using the services of a nonparticipating reference laboratory, which you would also like to utilize when providing services for BCBSNC members, please encourage the lab to contact BCBSNC for more information about becoming a contracting provider in our networks.

Reference labs that would like to participate in our networks are invited to complete an application, which can be downloaded at bcbsnc.com.

Settlement agreement update

BCBSNC has previously communicated information related to the settlement agreement Love, et al. v. Blue Cross Blue Shield Association, et al., formerly Thomas, et al. v. Blue Cross Blue Shield Association, et al. BCBSNC has made and is continuing to make enhancements to support greater transparency and operational efficiency. For information about the Thomas/Love Settlement Agreement and what BCBSNC is doing to comply, access BCBSNC online at bcbsnc.com for public information or log in to Blue e for secured information at providers.bcbsnc.com/providers/login.faces.
In April 2008, BCBSNC expanded the Centers of Excellence designation to include treatment of complex and rare cancers. This program helps a very specific patient population in need of skilled and dedicated facilities that treat these complicated cancers.

Complex and rare cancers comprise approximately 15 percent of new cancer cases each year, making it difficult for health care consumers to locate or research an oncologist or surgical team that is experienced in treating these specific malignancies.

Designation of Centers of Excellence for Complex and Rare Cancers focuses on multidisciplinary treatment planning and complex, major surgical treatments for the following malignancies:

- Acute leukemia (inpatient/non-surgical)
- Bladder cancer
- Bone cancer
- Brain cancer – primary
- Esophageal cancer
- Gastric cancer
- Head and neck cancers
- Liver cancer
- Ocular melanoma
- Pancreatic cancer
- Rectal cancer
- Soft tissue sarcomas
- Thyroid cancer – medullary or anaplastic

Selection criteria for BCBSNC Centers of Excellence for Complex and Rare Cancers set objective, evidence-based criteria for clinical care. All Centers of Excellence for Complex and Rare Cancers feature:

- Multidisciplinary team input, including sub-specialty trained teams for complex and rare cancers and demonstrated depth of expertise across cancer disciplines in medicine, surgery, radiation oncology, pathology and radiology
- Ongoing quality management and improvement programs for cancer care
- Ongoing commitment to using clinical data registries and providing access to appropriate clinical research for complex and rare cancers
- Sufficient volume of experience in treating rare and complex cancers

For a complete listing of the BCBSNC Centers of Excellence for Complex and Rare Cancers or for more information about all designated Centers of Excellence programs, visit bcbsnc.com or call 1-800-810-BLUE (2583).

Note: The BCBSNC Centers of Excellence for Complex and Rare Cancers program is a part of the Blue Distinction Centers for Complex and Rare Cancers™ program that was developed by the Blue Cross and Blue Shield Association, in collaboration with leading medical experts and professional organizations.

Using modifier 59 when billing two flu tests coded 87804 from one device

When ordering a rapid influenza test for patients presenting with flu-like symptoms it may be necessary to check for influenza A, influenza B, or both. Detection of both influenza A and B strains may be part of two entirely separate procedures or may be included within a single test device. If the assays provide two separate results (e.g., a result for influenza A and a result for influenza B), two units of 87804 may be appropriate. When reporting two units of 87804, modifier 59 should be used to indicate that the two results represent separate services and the second unit as a distinct procedural service.
To maintain quality, cost-effective health care for our members, BCBSNC is expanding its prior review program to include three infusible medications: Remicade, Orencia and Rituxan.

Prior review is the process by which BCBSNC reviews the provision of certain medical services and medications against health care management guidelines prior to the services being provided. Inpatient admissions, services and procedures received on an outpatient basis, such as in a doctor's office, and prescription medications may be subject to prior approval. Prior review is not required for emergency instances when the absence of medical attention could jeopardize a person's life, health, or ability to regain maximum function, or could subject a person to severe pain.

The prior review list is maintained and available on the BCBSNC Web site at bcbsnc.com/providers/ppa/services.cfm. The prior review list is considered as “notice of a change.” It is important to check the list quarterly. It is simple to use. Open the code list *.pdf file and select the Search button in the toolbar above the list. Enter in the code that you need to know about and click the Search button. If the code is available, it will be highlighted within the text.

BCBSNC updates the list in advance to allow 90 days notice for existing codes. Newly created codes may go directly to the list without 90 days notice. The ineffective date tells you the date that a code was removed from the prior review list. However, it is important to note that a claim submitted for up to 18 months past the ineffective date for services rendered prior to that date will be subject to prior review.

To learn more about prior review, contact your local Network Management representative.

Prior review now required for three infusible medications: Remicade, Orencia and Rituxan

To maintain quality, cost-effective health care for our members, BCBSNC is expanding its prior review program to include three infusible medications: Remicade, Orencia and Rituxan.

Prior review is the process by which BCBSNC reviews the provision of certain medical services and medications prior to the services being provided and based on supporting health care management guidelines. These reviews encourage the appropriate use of a prescribed medication and are based on the drug manufacturers’ guidelines and supporting medical literature. The prior review program requires that BCBSNC obtain the diagnosis and certain necessary clinical information from the prescribing doctor, before the drug in question is approved for payment.

Effective July 1, 2008, the prior review program will include Remicade, Orencia and Remicade. Remicade and Orencia will require prior review for all members, while the requirement for Rituxan will be only for the treatment of rheumatoid arthritis.

Prior review requests should be directed to our Member Health Partnership Operations at 1-800-672-7897. Details about the medical policy and fax forms that can be used to request prior review are available on our Web site at bcbsnc.com/providers/ppa/prescriptions.cfm.

For any member who has received one of these drugs between December 1, 2007 and June 30, 2008, they will be given an authorization without review for the period of time specified for an authorization in each drug's medical policy. Those authorization time periods for each drug are as follows: (1) Remicade, five years, (2) Orencia, five years and (3) Rituxan, six months. After this time period has passed, the prescribing physician will need to request a prior review using the normal prior review procedures.
BCBSNC 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.

BCBSNC 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 via our outreach efforts (direct phone calls, mailings, provider workshops, etc.) 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.do.

The following CMS sources can provide you with updates and information about NPI:

- cms.hhs.gov/HIPAAGenInfo
- cms.hhs.gov/NationalProviderStand

**Register your NPI with BCBSNC**

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. When you register your NPI with BCBSNC, the information is shared with our subsidiary, PARTNERS National Health Plans of North Carolina, Inc.

**NPI claims processing at BCBSNC**

BCBSNC began the NPI Dual Use phase in October 2006 and remained in Dual Use until moving to compliance May 23, 2008. Please note that with NPI Compliance, BCBSNC rejects any electronic transaction that does not contain an NPI. This includes all transactions executed through Blue e.

While BCBSNC policy currently does not require an NPI for paper submitted transactions, an NPI may be required for paper claims submission in mid-2009. Providers are encouraged to obtain and incorporate the NPI into their office practices accordingly.

**Helpful information for providers**

BCBSNC understands that this period of transition from using Legacy IDs to NPI can be challenging. Please feel free to contact BCBSNC regarding any questions you may have regarding our policies and procedures for NPI. Here are some helpful suggestions to ensure a smooth transition:

- Register all NPIs for your organization and its associated individuals with all payors including BCBSNC (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 payor.
- 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, please contact your local BCBSNC 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>
</tr>
</tbody>
</table>

For questions or issues concerning your electronic transactions, please contact e-Solutions Customer Service at 1-888-333-8594.
New vaccines added to the BCBSNC office-administered specialty drug network

BCBSNC offers the office-administered specialty drug network, which can supply you with select provider-administered injectable drugs for the treatment of your BCBSNC patients. By taking advantage of the office-administered specialty drug network, certain member specific and dose-specific injectable drugs can be delivered directly to your office, and the network vendors will bill BCBSNC directly for the drug.

Beginning in May 2008, three new vaccines have been added to the list of office-administered drugs available, these are:

- Gardisil Human Papilloma Virus (HPV) vaccine for the prevention of diseases caused by HPV in girls and women age 9 to 26.
- Zostavax Herpes Zoster vaccine for the prevention of herpes zoster in people ages 60 and older.
- AdacelTetanus, diphtheria toxoids and acellular pertussis vaccine or active booster immunization for the prevention of tetanus, diphtheria, and pertussis (whooping cough) as a single dose in persons 11 to 64 years of age.

A complete listing of the current pharmaceuticals available to you and your patients under the office-administered specialty drug network, as well as a listing of all additions or deletions (which will become effective at the beginning of the next quarter) can be viewed on our Web site at: bcbsnc.com/providers/injectable-drugs/available.cfm.

Vaccines

Disease prevention can be one of the most important steps to good health. It is 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. BCBSNC members are never to be asked to pick-up vaccines from the pharmacy for transport to a provider’s office, as this may result in unsafe temperature changes.

Vaccines should only be obtained by the administering provider and never by a BCBSNC member. Providers with questions are encouraged to contact their local network management representative.

Vaccine codes early release

Three vaccine codes for products that pended FDA approval were implemented on January 1, 2008, but will not be published until CPT 2009, these codes are:

90681 Rotavirus vaccine, human, attenuated, two-dose schedule, live, for oral use

90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use (**Approved by FDA and eligible for coverage as of 7/2/08)

90650 Human Papillomavirus vaccine HPV, types 16 and 18, bivalent, three-dose schedule for intramuscular use (correct code is 90649)

The American Medical Association (AMA) is removing the lightning bolt symbol from these codes as they receive FDA approval. Any changes that take effect before the next CPT manual is published can be found online at ama-assn.org/ama/pub/category/10902.html.
Radio frequency ablation of the inferior turbinates guidance

Symptomatic mucosal hypertrophy of the inferior turbinates, unresponsive to medical therapy, can be addressed using a variety of technologies, including cautery (monopolar or bipolar), cryotherapy, or radio frequency ablation (RFA). Regardless of the technology used, the goal is to produce an intramural tissue injury while preserving the overlying mucosa, without the risks associated with the alternative open surgical approach to turbinate reduction. The tissue injury and subsequent scarring lead to a reduction in bulk of the soft tissues, resulting in fewer congestive symptoms.

The CPT codes for cautery and or ablation procedures of the inferior turbinate include 30801 and 30802. CPT code 30802 refers to the submucosal and or mucosa sparing, volume reduction cautery and or ablation procedure, regardless of the technology used. Use of this code for RFA of the inferior turbinates is consistent with the coding guidelines from the American Academy of Otolaryngology-Head and Neck Surgery, which states on its Web site: “For RFA of the turbinates, use CPT code 30802, cautery and or ablation, mucosa of turbinates, unilateral or bilateral, any method; Submucous resection of turbinates (30140) is not the best suited code, even when the –52 modifier for reduced services is applied.”

This code is bilateral in nature; use of the -50 (for bilateral procedure) modifier if done on both sides, will not be expected. Supplies, topical vasoconstrictive agents, and local anesthesia are not reported separately.

Free resources to help your patients lose weight and manage diabetes

BCBSNC’s health management program, Member Health Partnerships, provides your patients many tools and benefits for losing weight and managing diabetes including six free nutrition counseling visits per year and health coaching.

By joining Member Health Partnerships, BCBSNC members can visit a credentialed registered dietitian six times per year with no copayment if they see an in-network provider in an office-based setting. Nutrition counseling can help your patients set goals to lose weight, monitor eating patterns and eat more healthfully.

Members can call health coaches 24 hours per day with questions about weight loss, healthy eating and physical activity. Your patients who enroll in Member Health Partnerships will receive support materials and tools such as calorie counters and a free pedometer.

Encourage your BCBSNC commercial patients (Blue Care®, Blue OptionsSM, and Blue Advantage®) to enroll in Member Health Partnerships by having them call 1-800-218-5295. To locate a credentialed nutritionist near you, go to bcbsnc.com. First click on “Find a Doctor” and then search by ZIP code for the “Nutrition (Licensed Dietitian)” specialty in your area.

* Some self-insured employer groups may choose not to offer this benefit.

Photochemotherapy involves treatment with drugs that react to ultraviolet radiation or sunlight. PUVA is a photochemotherapy treatment used to treat severe skin conditions such as psoriasis and other dermatoses. PUVA is a combination of Psoralens (P) and Ultraviolet A (UVA) radiation. Psoralens are photosensitizing agents (light-activated drugs) found in certain plants. A drug derived from Psoralens is taken by mouth approximately one to two hours before the Ultraviolet A treatment. When absorbed into the body, it has the opposite effect of a sunscreen. It makes the skin cells more susceptible to ultraviolet A (UVA) light. Topical psoralens (liquid or ointment) can be used in some cases prior to UVA treatment. BCBSNC members do not pay copayments for ultraviolet light therapy visits. In some instances it may be necessary to perform a separate E&M service on the same day as providing ultraviolet light therapy services, in which case the office visit E&M should be coded with a modifier 25 to identify a separately identifiable service from the ultraviolet light treatment.

To learn more about PUVA (Psoralens with Ultraviolet A) Therapy visit us on the Web at bcbsnc.com/services/medical-policy/pdf/puva_(psoralens_with_ultraviolet_a)_therapy.pdf.
Mental health parity

Effective July 1, 2008, or upon a group's subsequent renewal date, the Mental Health Parity Act changes the way that fully-insured groups and MEWAs (multiple employer welfare arrangements under ERISA) can administer benefits for the treatment of mental health conditions. These changes will be standard for ASO groups as well, unless they opt out. The changes include the treatments of the following nine mental illnesses that will not be subject to durational limits of inpatient / outpatient days and office visits:

- Bipolar disorder
- Major depressive disorder
- Obsessive compulsive disorder
- Paranoid and other psychotic disorder
- Schizoaffective disorder
- Schizophrenia
- Post traumatic stress disorder
- Anorexia nervosa
- Bulimia

All other covered mental conditions will be subject to coverage limits of 30 inpatient/outpatient days and 30 office visits. Providing “full coverage” means that copayments, deductibles, coinsurance, lifetime limits, and out-of-pocket maximum amounts for these mental illnesses will be the same as medical conditions under the member’s coverage plan.

Other changes:

- **Substance abuse:** While the law does not require that we apply the same changes to substance abuse coverage, covered substance abuse benefits will now apply to the member’s same common coinsurance and deductible.
- **Developmental delay:** Certain developmental delay diagnosis codes, including those for developmental dyslexia and other learning difficulties will now be covered, including those filed with a physical/occupational/speech/educational therapy code. These services will be limited to 30 inpatient/outpatient days and 30 office visits. Please note that services received in a school setting will continue to be excluded.
- **Sexual dysfunction:** Will no longer be subject to a separate lifetime maximum.
- **Psychoanalysis:** If a group is under Mental Health Parity, this will be paid as any other covered mental health procedure. HMO members will need to get preauthorization from Magellan, just as they do today for mental health services.

Expediting PET scan requests

Most PET scan requests received by AIM are evaluated at the RN or MD level of review. Often these requests end up in a peer-to-peer review, where the requesting MD speaks directly to an AIM physician about the request. In order to expedite the request process for PET scans and to lessen the possibility of the peer-to-peer, AIM has provided a PET “cheat sheet” that details all the clinical information that is needed for AIM to determine medical necessity for PET scans. Physician offices can either fill out the form and fax it to AIM or use the sheet as a checklist for the ordering physician prior to entering the information into the AIM Web Portal. The sheet can be distributed to any interested provider. Use of the sheet does not guarantee the automatic (Web or phone) approval of the request but should expedite the process if completed fully.

To access the PET “cheat sheet” visit us on the Web at: providers.bcbsnc.com/providers/imaging.faces.
Explanation of Payments (EOP) enhancements

BCBSNC has improved its system to make it easier for providers to understand the Explanation of Payment (EOP). As a result, beginning in mid-April 2008 you may have noticed a new message with a toll-free phone number and address you can use if you have questions about an EOP.

You will also notice new fields on the EOP:

- One will show the Number of Days used to calculate the Late Payment Interest
- Two fields will show the Non-Refunded Principal and Non-Refunded Interest amounts for an adjusted claim
- Another will show the Total Non-Refunded Principal for the entire remittance and
- Another will show the Total Non-Refunded interest for the entire remittance

Additionally, a new field was created to assist with tracking claims adjusted as a result of BCBSNC offsetting overpayments. Now when a claim is adjusted and results in a negative balance, the newly created field will display text reading Balance Forward (beginning balance amount) and/or any Ending Balance (ending balance amount) for the entire remittance being reported. See the example adjustment below.

Example of a claim adjustment for an overpayment in the amount of $75.00 dollars

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>ID Number</th>
<th>Dates of Service</th>
<th>Patient Number</th>
<th>Deductible Amount</th>
<th>Medical Rec Number</th>
<th>Place</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBSCRIBER Mary</td>
<td>W12345678901</td>
<td>11/29/2006</td>
<td>11/29/2006</td>
<td>-10.00</td>
<td>MRS123456</td>
<td>OFFICE</td>
<td>50.00</td>
</tr>
<tr>
<td>WELLNESS</td>
<td>99355</td>
<td>12345</td>
<td>11/29/2006</td>
<td>-5.00</td>
<td>MRS123456</td>
<td>OFFICE</td>
<td>20.00</td>
</tr>
<tr>
<td>LAB</td>
<td>87210</td>
<td>12345</td>
<td>11/29/2006</td>
<td>-20.00</td>
<td>MRS123456</td>
<td>OFFICE</td>
<td>-75.00</td>
</tr>
</tbody>
</table>

Example of a claim adjustment:

As example, if a claim was adjusted for an overpayment in the amount of $85.00 dollars and 45 days had past since BCBSNC sent a refund request letter for the $85.00 overpayment to be refunded, the next claim that processed may have the negative balance offset against the eligible benefit payment.

This new field does not change the current process for requesting refunds. In the event that we notice an overpayment in excess of the member’s benefits, BCBSNC will request in writing that a refund in the amount of the overpayment be returned. We ask that providers return to BCBSNC the benefit overpayment as soon as possible; however, if the refund is not received within 45 days of the written request, we may recover undisputed overpayment amounts by offsetting future claims payments. In the event that an overpayment is being collected by offset, any amount remaining as uncollected will display in the new EOP field as the Ending Balance (the balance remaining as uncollected).

As example, if a claim was adjusted for an overpayment in the amount of $85.00 dollars and 45 days had past since BCBSNC sent a refund request letter for the $85.00 overpayment to be refunded, the next claim that processed may have the negative balance offset against the eligible benefit payment.

(continued on page 17)
The negative Ending Balance from this example is $-10.00 dollars because $75.00 dollars of the eligible payment was withheld, leaving $10.00 dollars remaining of the $85.00 overpayment amount. This means that a -10.00 dollar negative balance remains and is listed on the EOP as the Ending Balance.

We hope that the new Ending Balance field on the EOP will help to streamline processes within your office for tracking claims adjustment in the event an adjustment, due to an overpayment, is ever initiated by BCBSNC. Please note that the new field will appear on EOP’s for claims processed on our Power MHS claims processing and payment system as of April 12, 2008.

Medical records requests
When medical records are needed to complete the processing of a claim, we will notify the provider, from whom records are needed, in writing and using a BCBSNC medical records request form. The medical records request form contains a routing code that allows the records to be scanned and sent directly to the individual in claims review, who is waiting to complete the processing of the pending claim(s).

If you receive a medical records request form, we want medical records form your health care business. It is important that we receive this form back from you, when you send us the medical records. Please place the form on top of the records so that we can scan and quickly route the records for processing.
How to improve responses for claim inquiries – Help us help you

We receive a high number of requests for claim and/or medical record review from providers. In an effort to help increase the number of claim and/or medical record requests we can review timely, we want to provide you with a list of the main reasons that may contribute to your requesting a re-review of your claim or a medical record. This lack of information may also contribute to a request being delayed or possibly not be responded to. Please review this information and ensure that your claims and any requests for review are complete and accurate before submitting them to BCBSNC. This will help you to decrease the inconvenience of having to call to inquire of the status of your request.

The main reasons that requests for re-review of claims/medical records may not be reviewed timely include:

- Invalid or missing NPI(s) or for paper filers the BCBSNC individual or group provider number
- Invalid, incomplete or missing member ID (please include the complete member ID including applicable prefixes and suffixes as they appear on the member’s current ID card)
- Invalid place-of-service code (filing one-digit code instead of a two-digit code)
- Missing or incorrect number of units
- Missing patient’s date of birth
- Missing onset date of symptoms
- Missing or incomplete specific diagnosis
- Missing primary payer’s EOB if BCBSNC is secondary
- Missing admission and discharge dates for inpatient claims

Medical records

For initial medical records submission, please do not send medical records unless requested by BCBSNC. We will send you a medical record request form with the required information; this must be returned with the records requested. This medical request form is critical to getting your medical records routed to the correct area to review. Not submitting your medical records with the medical record request form contributes to the delay or possibly loss of the medical record.

Filing with unlisted codes

Per CPT/HCPCS coding guidelines, all unlisted codes require the submission of pertinent records, such as the operative report, detailed description of the service in question, etc. to support the use of the unlisted code. This supporting information is required in order for us to make coverage and pricing determinations. By submitting it with the claim, you prevent any payment delay that will result if we have to request medical records.

For unlisted drugs, such as codes J3490, J3590, J9999, we require the NDC number, the name and dosage of the drug provided. If there is a valid CPT or HCPCS code, then do not submit the unlisted code.
New generics

Generic equivalents for the following drug products have recently become available. These generic products are available at the lowest copayment level, Tier 1, on the BCBSNC commercial and Medicare Part D formularies.

Remember to tell your patients that the FDA requires generic drugs to have the same quality, strength, purity and stability as their brand-name counterparts. Save money for your patients and prescribe generic drug products when appropriate.

Tier 1 - New generics (Lowest copayment amount)

<table>
<thead>
<tr>
<th>Brand-name</th>
<th>Generic</th>
<th>Therapeutic class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biaxin XL</td>
<td>Clarithromycin ER</td>
<td>Macrolides</td>
</tr>
<tr>
<td>Altace capsule</td>
<td>*Ramipl 2.5, 5, 10 mg caps</td>
<td>ACE Inhibitors</td>
</tr>
<tr>
<td>Trileptal tablet</td>
<td>Oxcarbazepine tablet</td>
<td>Anticonvulsants</td>
</tr>
<tr>
<td>Combunox</td>
<td>Oxycodone / Ibuprofen</td>
<td>Combination Narcotic Analgesics</td>
</tr>
<tr>
<td>Voltaren 0.1% ophthalmic drops</td>
<td>Diclofenac sodium</td>
<td>Ophthalmic NSAIDs</td>
</tr>
<tr>
<td>Kytril tablet</td>
<td>Granisetron</td>
<td>Antivertigo &amp; Antiemetic Agents</td>
</tr>
<tr>
<td>Protonix</td>
<td>Pantoprazole</td>
<td>Proton Pump Inhibitors</td>
</tr>
<tr>
<td>Colazal</td>
<td>Balsalazide disodium</td>
<td>Miscellaneous Gastrointestinal Agents</td>
</tr>
<tr>
<td>Fosamax tablet</td>
<td>Alendronate</td>
<td>Osteoporosis Therapy</td>
</tr>
<tr>
<td>Uniphyl</td>
<td>Theophylline SR</td>
<td>Xanthines</td>
</tr>
<tr>
<td>Accuneb</td>
<td>Albuterol sulfate for nebulization</td>
<td>Miscellaneous Neurological Therapy</td>
</tr>
<tr>
<td>Duoneb</td>
<td>Albuterol sulf / Ipratropium bromide for nebulization</td>
<td>Antihypertensive Combinations</td>
</tr>
</tbody>
</table>

*Distribution of generic Ramipl may be limited.

Commercial drug formulary update

BCBSNC and its Pharmacy & Therapeutics (P&T) Committee have reviewed the following new drug products and made the following decisions regarding their formulary tier (copayment) placement on the BCBSNC commercial formulary.

Tier 2 – Preferred brands (second-lowest copayment amount)

<table>
<thead>
<tr>
<th>Brand-name</th>
<th>Generic</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isentress</td>
<td>Raltegravir</td>
<td>HIV / AIDS Therapy</td>
</tr>
<tr>
<td>Selzentry</td>
<td>Maraviroc</td>
<td>HIV / AIDS Therapy</td>
</tr>
<tr>
<td>Exelon Patch</td>
<td>Rivastigmine transdermal patch</td>
<td>Miscellaneous Neurological Therapy</td>
</tr>
<tr>
<td>Azor</td>
<td>Amlodipine / Olmesartan</td>
<td>Antihypertensive Combinations</td>
</tr>
<tr>
<td>Clorpres</td>
<td>Clonidine / Chlorthalidone</td>
<td>Antihypertensive Combinations</td>
</tr>
<tr>
<td>Exforge</td>
<td>Amlodipine / Valsartan</td>
<td>Antihypertensive Combinations</td>
</tr>
<tr>
<td>Lexxel</td>
<td>Felodipine / Enalapril</td>
<td>Antihypertensive Combinations</td>
</tr>
<tr>
<td>*Lotrel 5/40mg, 10/40mg</td>
<td>Amlodipine / Benazepril</td>
<td>Antihypertensive Combinations</td>
</tr>
</tbody>
</table>

*Generic equivalents are available for all other strengths of Lotrel.

(continued on page 20)
**Commercial drug formulary update**

BCBSNC and its Pharmacy & Therapeutics (P&T) Committee have reviewed the following new drug products and made the following decisions regarding their formulary tier (copayment) placement on the BCBSNC commercial formulary.

<table>
<thead>
<tr>
<th>Tier 2 – Preferred brands (second-lowest copayment amount)</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brand-name</strong></td>
<td><strong>Generic</strong></td>
</tr>
<tr>
<td>Tarka</td>
<td>Verapamil / Trandolapril</td>
</tr>
<tr>
<td>Innopran XL</td>
<td>Propranolol SR</td>
</tr>
<tr>
<td>Coreg CR</td>
<td>Carvedilol CR</td>
</tr>
<tr>
<td>Catapres TTS</td>
<td>Clonidine transdermal patch</td>
</tr>
<tr>
<td>Cardene SR</td>
<td>Nicardipine SR</td>
</tr>
<tr>
<td>Covera HS</td>
<td>Verapamil SR</td>
</tr>
<tr>
<td>Dynacirc CR</td>
<td>Isradipine SR</td>
</tr>
<tr>
<td>Sular</td>
<td>Nisoldipine</td>
</tr>
<tr>
<td>Aldactazide 50-50mg</td>
<td>Spironolactone / HCTZ</td>
</tr>
<tr>
<td>Dyrenium</td>
<td>Triamterene</td>
</tr>
<tr>
<td>Edecrin</td>
<td>Ethacrynic acid</td>
</tr>
<tr>
<td>Inspra</td>
<td>Eplerenone</td>
</tr>
<tr>
<td>Thalitone</td>
<td>Chlorthalidone 15mg</td>
</tr>
<tr>
<td>BiDil</td>
<td>Hydralazine / Isosorbide dinitrate</td>
</tr>
<tr>
<td>Atacand</td>
<td>Candesartan</td>
</tr>
<tr>
<td>Atacand HCT</td>
<td>Candesartan / HCTZ</td>
</tr>
<tr>
<td>Avapro</td>
<td>Irbesartan</td>
</tr>
<tr>
<td>Avalide</td>
<td>Irbesartan / HCTZ</td>
</tr>
<tr>
<td>Benicar</td>
<td>Olmesartan</td>
</tr>
<tr>
<td>Benicar HCT</td>
<td>Olmesartan / HCTZ</td>
</tr>
<tr>
<td>Teveten</td>
<td>Eprosartan</td>
</tr>
<tr>
<td>Teveten HCT</td>
<td>Eprosartan / HCTZ</td>
</tr>
<tr>
<td>Byetta</td>
<td>Exenatide</td>
</tr>
<tr>
<td>Glyset</td>
<td>Miglitol</td>
</tr>
<tr>
<td>Prandin</td>
<td>Repaglinide</td>
</tr>
<tr>
<td>Starlix</td>
<td>Nateglinide</td>
</tr>
<tr>
<td>Symlin</td>
<td>Pramlintide acetate</td>
</tr>
<tr>
<td>Advicor</td>
<td>Lovastatin / Niacin ER</td>
</tr>
<tr>
<td>Caduet</td>
<td>Atorvastatin / Amlodipine</td>
</tr>
<tr>
<td>Lescol</td>
<td>Fluvasatinn</td>
</tr>
<tr>
<td>Lescol XL</td>
<td>Fluvasatinn SR</td>
</tr>
</tbody>
</table>

*HCTZ = hydrochlorothiazide*
New generics  
*(Continued from page 21)*

### Tier 2 – Preferred brands (second-lowest copayment amount)

<table>
<thead>
<tr>
<th>Brand-name</th>
<th>Generic</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipofen</td>
<td>Fenofibrate</td>
<td>Lipid / Cholesterol Lowering Agents</td>
</tr>
<tr>
<td>Lovaza (Omacor)</td>
<td>Omega-3 acid ethyl esters</td>
<td>Lipid / Cholesterol Lowering Agents</td>
</tr>
<tr>
<td>Welchol</td>
<td>Colesevelam</td>
<td>Lipid / Cholesterol Lowering Agents</td>
</tr>
<tr>
<td>Zetia</td>
<td>Ezetimibe</td>
<td>Lipid / Cholesterol Lowering Agents</td>
</tr>
</tbody>
</table>

*Generic equivalents are available for all other strengths of Lotrel.

HCTZ = hydrochlorothiazide

### Tier 3 – Brands (second-highest copayment amount)

<table>
<thead>
<tr>
<th>Brand-name</th>
<th>Generic</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neupro</td>
<td>Rotigotine transdermal patch</td>
<td>Antiparkinsonism Agents</td>
</tr>
<tr>
<td>Endometrin</td>
<td>Progesterone vaginal insert</td>
<td>Progestins</td>
</tr>
<tr>
<td>Xyzal</td>
<td>Levocetirizine</td>
<td>Antihistamines</td>
</tr>
<tr>
<td>Extina</td>
<td>Ketoconazole aerosol foam</td>
<td>Topical Antifungals</td>
</tr>
<tr>
<td>Perforomist</td>
<td>Formoterol fumarate inhalation soln</td>
<td>Beta Agonist Inhalers</td>
</tr>
<tr>
<td>Zyflo CR</td>
<td>Zileuton extended-release tabs</td>
<td>Miscellaneous Pulmonary Agents</td>
</tr>
<tr>
<td><em>Letairis</em></td>
<td>Ambrisantan</td>
<td>Miscellaneous Pulmonary Agents</td>
</tr>
<tr>
<td><em>Pulmozyme</em></td>
<td>Dornase alfa</td>
<td>Miscellaneous Pulmonary Agents</td>
</tr>
<tr>
<td><em>TOBI</em></td>
<td>Tobramycin for nebulization</td>
<td>Miscellaneous Anti-Infectives</td>
</tr>
<tr>
<td><em>Gleevec</em></td>
<td>Imatinib mesylate</td>
<td>Miscellaneous Antineoplastic Drugs</td>
</tr>
<tr>
<td><em>Nexavar</em></td>
<td>Sorafenib</td>
<td>Miscellaneous Antineoplastic Drugs</td>
</tr>
<tr>
<td><em>Revlimid</em></td>
<td>Lenalidomide</td>
<td>Miscellaneous Antineoplastic Drugs</td>
</tr>
<tr>
<td><em>Sutent</em></td>
<td>Sunitinib</td>
<td>Miscellaneous Antineoplastic Drugs</td>
</tr>
<tr>
<td><em>Alkeran tablet</em></td>
<td>Melphalan tablet</td>
<td>Alkylating Agents</td>
</tr>
<tr>
<td><em>CEENU</em></td>
<td>Lomustine</td>
<td>Alkylating Agents</td>
</tr>
<tr>
<td><em>Leukeran</em></td>
<td>Chlorambucil</td>
<td>Alkylating Agents</td>
</tr>
<tr>
<td><em>Temodar</em></td>
<td>Temozolomide</td>
<td>Alkylating Agents</td>
</tr>
<tr>
<td><em>Casodex</em></td>
<td>Bicalutamide</td>
<td>Antiandrogens</td>
</tr>
<tr>
<td><em>Arimidex</em></td>
<td>Anastrozole</td>
<td>Antiestrogens</td>
</tr>
<tr>
<td><em>Aromasin</em></td>
<td>Exemestane</td>
<td>Antiestrogens</td>
</tr>
<tr>
<td><em>Femara</em></td>
<td>Letrozole</td>
<td>Antiestrogens</td>
</tr>
<tr>
<td><em>Fareston</em></td>
<td>Toremifene citrate</td>
<td>Antiestrogens</td>
</tr>
<tr>
<td><em>Xeloda</em></td>
<td>Capecitabine</td>
<td>Antimetabolites</td>
</tr>
<tr>
<td><em>Mesnex tablet</em></td>
<td>Mesna tablet</td>
<td>Adjunctive Agents</td>
</tr>
<tr>
<td><em>Aranesp</em></td>
<td>Darbepoetin alfa</td>
<td>Erythroid Stimulants</td>
</tr>
<tr>
<td><em>Neupogen</em></td>
<td>Filgrastim</td>
<td>Myeloid Stimulants</td>
</tr>
</tbody>
</table>

*(continued on page 22)*
New generics
(Continued from page 21)

<table>
<thead>
<tr>
<th>Tier 3 – Brands (second-highest copayment amount)</th>
<th>Brand-name</th>
<th>Generic</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Copaxone</td>
<td>Glatiramer acetate</td>
<td>Miscellaneous Neurological Therapy</td>
<td></td>
</tr>
<tr>
<td>*Avonex</td>
<td>Interferon beta-1a</td>
<td>Interferons</td>
<td></td>
</tr>
<tr>
<td>*Betaseron</td>
<td>Interferon beta-1b</td>
<td>Interferons</td>
<td></td>
</tr>
<tr>
<td>*Rebif</td>
<td>Interferon beta-1a</td>
<td>Interferons</td>
<td></td>
</tr>
<tr>
<td>*Pegasys</td>
<td>Peginterferon alfa-2a</td>
<td>Interferons</td>
<td></td>
</tr>
<tr>
<td>*PEG-Intron</td>
<td>Peginterferon alfa-2b</td>
<td>Interferons</td>
<td></td>
</tr>
<tr>
<td>*Baraclude</td>
<td>Entecavir</td>
<td>Miscellaneous Antivirals</td>
<td></td>
</tr>
<tr>
<td>*Epivir HBV</td>
<td>Lamivudine</td>
<td>Miscellaneous Antivirals</td>
<td></td>
</tr>
<tr>
<td>*Hepsera</td>
<td>Adefovir dipivoxil</td>
<td>Miscellaneous Antivirals</td>
<td></td>
</tr>
<tr>
<td>*Valcyte</td>
<td>Valganciclovir</td>
<td>Miscellaneous Antivirals</td>
<td></td>
</tr>
<tr>
<td>*Sensipar</td>
<td>Cinacalcet</td>
<td>Miscellaneous Agents</td>
<td></td>
</tr>
<tr>
<td>*Oxsoralen</td>
<td>Methoxsalen</td>
<td>Miscellaneous Dermatologicals</td>
<td></td>
</tr>
</tbody>
</table>

*Considered preferred specialty drug.

<table>
<thead>
<tr>
<th>Tier 4 – Specialty drugs (coinsurance amount)</th>
<th>Brand-name</th>
<th>Generic</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Tasigna</td>
<td>Nilotinib</td>
<td>Miscellaneous Antineoplastic Drugs</td>
<td></td>
</tr>
<tr>
<td>Somatuline Depot</td>
<td>Lanreotide acetate</td>
<td>Miscellaneous Antineoplastic Drugs</td>
<td></td>
</tr>
</tbody>
</table>

*For those members with the 4-tier formulary.
Electronic Solutions: Updates and reminders

Blue e Application Tips

Electronic solutions continues Blue e redesign

There have been improvements and changes to Blue e since 2007. More changes are taking place in 2008. In the spring, the Federal Employee Program (FEP) Name Search and Clear Claim Connection (C3) transactions were redesigned. The transactions now have a new look and feel. e-Solutions is also making available a new training tool to allow users to view information and simulation of the Blue e transactions. The new online training tool is an Electronic User Guide and is available on Blue e. Please reference the Electronic User Guide for information on the FEP Name Search and C3.

Remittance Inquiry

The Blue e Remittance Inquiry allows users to view, print, or save copies of their paper Notification of Payment (NOP) and Explanation of Payment (EOP) files. The files available for download are electronic copies of the actual paper NOP/EOP remits you receive via US mail. The EOP files for BCBSNC’s Blue Products are available for 365 days. The NOP/EOPs are PDF files. Use the binocular icon in the Acrobat Reader window to perform a search for data (i.e. Patient Account Number, Patient Name, BCBS ID number) in the EOP/NOP. More improvements to this transaction are taking place. Please review “What's New” and “Important Messages” for more details.

Corrected claims

In general, a corrected claim is any claim for which you have received a notification of payment (NOP) or explanation of payment (EOP), and for which you need to make corrections on the original submission. Corrections can be additions (e.g. late charges), a replacement of the original claim, or a cancellation of the previously submitted claim.

Blue e online claims

Institutional corrected claims can be submitted through the Blue e UB-04 transaction. Indicate the corrected claim by setting the Frequency Code, which is the last digit of the bill type on the Blue e UB-04 transaction. On the UB-04, the bill Frequency code is in Form Locator 4.

New feature: Professional corrected claims can now be submitted by direct data entry through the Blue e CMS-1500 transaction. Indicate the corrected claim by setting the Corrected Claim flag to ‘Yes’ on the Blue e CMS-1500 transaction Add screen.

837 Institutional or Professional x12 Claims

Institutional corrected claims can be submitted electronically using the 837 Institutional Claim transaction. Specify the corrected claim indicator in loop 2300; segment CLM05-3 on the 837 Institutional Claim transaction.

Professional corrected claims can be submitted electronically using the 837 Professional Claim transaction. Specify the corrected claim indicator in loop 2300; segment CLM05-3 on the 837 Professional Claim transaction.

EOP codes requiring new claim submission

If you received an EOP with any of the following codes, please do not submit a corrected claim. Submit a new claim to allow the claim to be correctly processed.

Code – Explanation

EM0 - Incorrect place of service for service.
EM1 - Claim denied for invalid procedure code. Please resubmit correct procedure code.
EM2 - Claim denied. Please resubmit procedure code for which anesthesia was provided.
EM3 - Claim has been mailed back for additional information.
EM4 - Claim submitted with incorrect or inactive provider or group number. Please resubmit claim with a correct provider or group number.
EM5 - Resubmit split billing for authorized days.
EM6 - Services for newborn need to be split into two claims. For normal delivery, split for 48 hours and for c-section, split for 96 hours. Resubmit as two claims.
EM8 - Our records indicate for the date of service filed, the individual provider was not part of the group’s practice. Please resubmit claim with an active provider or group number.
EM9 - Claim denied for incorrect bill type for services(s) rendered. Please resubmit with correct bill type.

(continued on page 24)
Electronic Solutions: Updates and reminders
(continued from page 23)

Manage account

Providers with existing Blue e accounts are not required to complete a new agreement to make user and provider ID changes. The Manage Account transaction on the Blue e Home Page under the Administrative Heading is used to add or remove a User ID or Provider ID from your Blue e account profile. This transaction enables requests to be handled electronically instead of fax. Click on the hyperlink identifying the task you want to perform.

Hyperlinks:

Add users
Use this hyperlink to add a user ID to your Blue e account.

Remove users
Use this hyperlink to delete a user ID from your Blue e account.

Add providers
Use this hyperlink to add a provider number to your Blue e account.

Remove providers
Use this hyperlink to delete a provider number from your Blue e account.

Self-Administered provider sites should continue to contact their Entity Administrator for user or provider ID changes.

Blue e – NPI compliance May 23, 2008

Since May 23, 2008, Blue e transactions must use a BCBSNC Provider ID. Use your appropriate NPI that has been registered with BCBSNC. If you need to register your NPI with BCBSNC, use the NPI Registration transaction. For more information, see the NPI Registration Job Aid, located on the Home → Help page.

Electronic funds transfer

Participating providers may complete an Electronic Funds Transfer (EFT) Authorization Form to have claims payments deposited directly to your bank account. Direct deposit payments are generally faster and safer than paper checks. The form can be found at bcbsonc.com/providers/edi/hipaainfo.cfm.

Instructions for completing and submitting the form are included. EFT is available for all lines of business except FEP.

Blue Medicare HMO and Blue Medicare PPO reminders

BCBSNC is the parent company of PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS), a health care company based in Winston-Salem. If you are not already familiar with PARTNERS, this Medicare Advantage organization provides HMO and PPO plans for more than 43,000 people within the state.

We told you in the 2008 Winter edition of Blue Link that PARTNERS had received a license to identify itself as an affiliate of the Blue Cross and Blue Shield Association. This affiliate designation allows PARTNERS HMO and PPO products to be branded with the Blue Cross and Blue Shield symbols, replacing the Medicare Choice HMO and Medicare Options PPO products with the new Blue Medicare HMO and Blue Medicare PPO.

Effective January 1, 2008, Blue Medicare HMO and Blue Medicare PPO members received new identification cards featuring a “blue” look. These new cards feature the Blue Cross and Blue Shield symbols and are for members who have health care coverage with PARTNERS. This means that when arranging health care and/or submitting claims for services provided to Blue Medicare HMO and Blue Medicare PPO members, PARTNERS in Winston-Salem remains the chief contact. Even with this change, we have worked to make the member cards distinctive, so you can easily determine whether a claim or question should be directed to PARTNERS or BCBSNC. Please see the sample card image on the next page.

(continued on page 25)
It is 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 YPWJ lets you know that the member’s coverage type is an HMO plan. If you see YPFJ, you know the coverage type is PPO. Additionally, Reynolds American, Inc. retirees have a customized alpha prefix of YPJJ, making them easy to identify as having an individualized HMO plan. Any time that you are presented with one of these alpha prefixes, you will know that the claims and health care services are administered by PARTNERS.

The back of a Blue Medicare member’s identification card provides further information about arranging health care services and claim submission with PARTNERS. The cards also display the PARTNERS claims mailing address and telephone service lines.

With a quick glance of the front of the card, you can see in the upper right-hand corner that the member has a Blue Medicare plan and the type of plan the member has chosen is also specified. Just below that, you can see an area shaded in blue that highlights the plan as offered by PARTNERS, which is identified as a BCBSNC company. On the left-hand side of the card, the Blue Medicare member’s ID includes an alpha prefix. Blue Medicare alpha prefixes are unique to Blue Medicare members and always end with the letter J. The following alpha prefixes identify Blue Medicare plan types:

![Image of a Blue Medicare identification card with highlighted areas]

The following alpha prefixes identify Blue Medicare plan types:

- **YPWJ** – Blue Medicare HMO
- **YPFJ** – Blue Medicare PPO
- **YPJJ** – Blue Medicare HMO for Reynolds American Inc. retirees

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

Blue Medicare HMO and Blue Medicare PPO ID cards are readily recognizable, but remember that the cards include both BCBSNC and PARTNERS information. It is important that you review the cards carefully and note the Blue Medicare HMO and Blue Medicare PPO alpha prefixes and PARTNERS health plan information. Do not 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 as in-network for Blue Medicare HMO and Blue Medicare PPO. Participation with BCBSNC does not extend to Blue Medicare HMO and/or Blue Medicare PPO.

- BCBSNC participating providers that are not contracted with PARTNERS can provide services to Blue Medicare PPO members as part of the member’s PPO out-of-network benefits.

- Blue Medicare HMO members have no out-of-network benefits (except for emergency care).

- Plans have unique alpha prefixes:
  - YPWJ – Blue Medicare HMO (no out-of-network benefits – emergency care only)
  - YPFJ – Blue Medicare PPO (out-of-network benefits available)
  - YPJ – Blue Medicare HMO (most services require referrals from Winston-Salem Health Care)
  - Providers participating with both BCBSNC and PARTNERS cannot use Blue e electronic transactions for Blue Medicare HMO and Blue Medicare PPO claims and/or member information.

- Claims submitted to BCBSNC for Blue Medicare HMO and Blue Medicare PPO members in error will be returned to the submitting provider or electronic clearinghouse. This includes both paper and electronic claims.

- BCBSNC health coaching services, claims processing, post adjudication review and medical policy do not apply to Blue Medicare HMO and Blue Medicare PPO. These services and functions are administered by PARTNERS at its Winston-Salem location.

Interested in seeing Blue Medicare HMO and/or Blue Medicare PPO members?

If your health care location participates with BCBSNC but not with PARTNERS, please contact your local network management field office to find out how your health care business can become an in-network provider for Blue Medicare HMO and/or Blue Medicare PPO members.

(continued on page 27)
Product logos make Blue Medicare HMO and Blue Medicare PPO plans more recognizable as an affiliate of the Blue Cross and Blue Shield Association. However, the name Blue Medicare also applies to BCBSNC prescription and supplemental plans as shown below.

As you can see, the logos for the BCBSNC products and PARTNERS products appear very similar. However, you can easily distinguish between BCBSNC products and PARTNERS products with the following information:

1. Logos for Blue Medicare HMO and Blue Medicare PPO\(^1\) both include text in their design that reads: “Offered by PARTNERS National Health Plans of North Carolina, Inc.”

2. Logos for Blue Medicare HMO and Blue Medicare PPO include either an HMO or PPO designation in their design.

**Reminder:** When filing claims always send claims for Blue Medicare HMO and Blue Medicare PPO services to PARTNERS National Health Plans of North Carolina, Inc. Claims for Blue Medicare Rx and Blue Medicare Supplement should be filed with BCBSNC.\(^2\)

1. Blue Medicare HMO and Blue Medicare PPO are replacement names for PARTNERS Medicare Choice and Medicare Options HMO and PPO health care benefit plans.

2. Blue Medicare Rx is a prescription drug coverage plan for Medicare beneficiaries, which is sponsored by Medicare and provided through BCBSNC. Blue Medicare Supplement plans are supplemental health plans offered by BCBSNC for Medicare beneficiaries enrolled in Medicare Part B. To learn more about Blue Medicare Rx and/or Blue Medicare Supplement, visit bcbsnc.com/plans/medicareplans.cfm.
BCBSNC changes dependent coverage age to 26

Effective at a group’s renewal date beginning in September 2008, BCBSNC will change the dependent coverage age to 26 regardless of student status for all insured group business. We will also offer this as the standard option for ASO groups to choose. BCBSNC has already changed the dependent coverage age to 26 for its own employer group, as of January 1, 2008.

However, there may be exceptions for large groups that are fully insured. The standard dependent age will be set to 26 years of age, but large groups that currently deviate from the standard dependent age and/or student status verification guidelines will be allowed to retain the flexibility to modify the dependent age as requested. ASO groups will also have the flexibility to set their own dependent age and student status re-certification limits.