Providers Can Improve the Quality of Patient Care by Closing Care Gaps

As payers move toward more quality- and outcomes-based reimbursement and rewards, closing gaps in patient care becomes more important. By closing these gaps in care, providers can improve the quality of patient care and in turn, decrease medical expense.

In 2012, Blue Cross and Blue Shield of North Carolina (BCBSNC) introduced several tools designed to assist primary care providers with identifying and closing gaps in care. The Provider Performance Analytics Report is mailed to practices, and the Patient Care Summary (individual member-specific information) is available via Blue eSM. These tools can be very valuable to your practice. They can also be very useful for practices seeking Patient-Centered Medical Home recognition and participation in the Blue Quality Physician ProgramSM. For more information about these programs, please visit our website at bcbsnc.com/providers.

Recently, BCBSNC Quality Management consultants began visiting practices that were identified as having a higher percentage of members with potential gaps in care. A full quality review is conducted and the consultant assists these practices in identifying care gaps, as well as offers solutions/assistance to close the gaps.

Although your practice may not be reviewed, it is your responsibility to understand and comply with BCBSNC Quality Standards (Access to Care, Facility and Medical Records Standards). Providers are encouraged to continue to review practice standards located online at bcbsnc.com/providers for any changes or updates.
Follow-Up Visit to Be Scheduled Within 7 Days
After Inpatient Mental Health or Substance Abuse Stays

BCBSNC delegates the administration of mental health services and substance abuse management (including certification, concurrent review, discharge planning, and case management) to Magellan Health Services.

BCBSNC and Magellan are committed to providing the best care possible to our members. An integral part of this commitment is working with facilities to ensure that members discharged from an inpatient level of care should have a scheduled aftercare appointment with a mental health provider within seven days of discharge as part of aftercare compliance and to prevent readmissions. With this shared goal in mind, we would like to remind you of the importance of ensuring that our members receive timely ambulatory follow-up appointments after hospitalization from an acute care setting.

Tips to Ensure Successful Follow-Up Care After Hospitalization

• Discharge planning is expected to begin on the day of admission and should include the utilization review staff, discharge planner, the member’s family (at discretion of the member), significant others, guardian, or others as desired by the member.

• Admitting facility should ensure that discharged members have scheduled, verifiable follow-up appointments (not walk-in appointments) with a behavioral health provider or psychiatrist within seven days of discharge from an acute inpatient setting.

• A weekend discharge should not be a barrier for making sure the aftercare appointments are in place at the time of discharge.

• Magellan can provide you with a list of outpatient behavioral health network providers or psychiatrists, and they will assist you with any scheduling challenges before the member is discharged, if needed.

• An aftercare appointment with the member’s primary care physician should not be the only appointment in place upon the member’s discharge from an inpatient level of care.

• Discharging the member solely to a group home, assisted living facility, Alcoholics Anonymous, or Narcotics Anonymous is not an appropriate discharge plan.

• A member should not be discharged from a facility with instructions to set their own follow-up appointment. Either assist the member in contacting the provider of choice by having them contact

the provider and make the appointment while still inpatient, or see assistance from Magellan to schedule the follow-up appointment before the member is discharged.

• Explain the benefits of aftercare to the member, so he or she understands the importance of keeping these follow-up appointments.

• Verify with the member that the aftercare plan is a good fit for him or her (e.g., transportation is not problematic, time of the appointment will work, etc.).

• Involve and educate the member’s family to support the aftercare plan.

• Explain to the member the importance of staying on medication and notifying the prescribing physician of any side effects.

Important Billing Information: Please remember to submit all claims to BCBSNC as soon as possible. This enables us to reconcile with the National Committee for Quality Assurance (NCQA) and other entities for timely reporting.

Thank you for your cooperation, which enables us to comply with NCQA requirements, as well as helps ensure that our members receive the service they need when they need it.
Allowed Documentation for HEDIS Follow-Up After Hospitalization Measure

HEDIS® Follow-Up After Hospitalization (FUH) is a performance measure from the National Committee for Quality Assurance (NCQA), which is annually reported to NCQA by America’s health plans to measure performance.

NCQA has changed their rules about what is considered allowed documentation required to support the FUH measure. Only member follow-up visits that are supported by a claim, encounter or note from the provider’s medical chart will be allowed as evidence for the purposes of 2014 HEDIS measures (meaning 2013 actual dates of service).

BCBSNC delegates mental health and substance abuse administration to Magellan Health Services. Allowing Magellan’s authorized follow-up specialist staff to obtain patient information for appropriate ambulatory follow-up purposes complies with the HIPAA Privacy Rule.

In order to demonstrate that our members are receiving appropriate follow-up care following an inpatient hospital stay, BCBSNC is required by NCQA to obtain evidence of aftercare follow-up treatment.

In order to assist us with collecting this required evidence, Magellan may seek this information from your office on our behalf as part of our case management and/or care coordination activities to help ensure that BCBSNC members receive the best possible care.

What is considered allowed documentation evidence?

- **Claims** for services rendered and sent to BCBSNC by provider for payment.
- **Note** from the member’s medical chart with identifying provider information attached.
- **Encounter form** faxed to provider from Magellan requesting confirmation of services rendered.

**Important Billing Information:** Please remember to file all claims to BCBSNC by the end of the year, as this enables us to reconcile with NCQA and other entities for timely reporting.
ICD-10 Codes Required for Dates of Service Beginning October 1, 2014

BCBSNC is preparing for the health care industry’s conversion to the 10th version of the International Classification of Diseases code set (ICD-10). In compliance with HHS regulations, all HIPAA-covered entities are required to use ICD-10 on all transactions, including claims, authorizations, referral requests, and verification of benefits and eligibility. The industry-wide conversion to ICD-10 will occur on October 1, 2014.

BCBSNC is taking the necessary steps to ensure that all of its systems and processes will accommodate ICD-10 by the federal compliance date. All electronic or paper-based transactions for services on or after October 1, 2014, must contain ICD-10 codes or they will be rejected.

Under the Administrative Simplification provision requirements, if providers use ICD-9 codes in transactions for services or discharge dates on or after October 1, 2014, the claim will be rejected as noncompliant, and the transaction will not be processed. Therefore, providers may experience disruptions in transactions being processed and receipt of payments if they submit noncompliant transactions.

BCBSNC urges all HIPAA-covered entities to be fully prepared for ICD-10 implementation. ICD-10 implementation will change how a practice operates. Any business process or technology that stores, processes, or utilizes medical/diagnosis/procedure codes will be affected on some level.

BCBSNC will be ICD-10 compliant on October 1, 2014. In accordance with the federal mandate, please note the following:

- Claims submitted to BCBSNC with dates of service or discharge dates on or after October 1, 2014, must be submitted with the appropriate ICD-10 code (ICD-10 codes as of October 1, or ICD-9 codes for dates of service prior to October 1).
- BCBSNC WILL NOT accept claims with ICD-9 codes for dates of service on or after October 1, 2014. These claims will not be paid until they are submitted with the correct ICD-10 codes.
- Provider noncompliance will increase business disruption for provider billing staff and for BCBSNC, as well as disrupt provider revenue stream.

For more information and additional ICD-10 resources, please visit BCBSNC’s Countdown to ICD-10 Compliance website.

New ICD-10 Codes Specified in Medical Policies

At the time of this article, BCBSNC has identified 20 medical policies that involve ICD-coding changes, and updated them from the current ICD-9 codes to reflect the new ICD-10 codes in the billing/coding sections of each respective medical policy that is affected.

Please go to bcbsnc.com/content/services/medical-policy/updates/medical-policy-updates-2013-07-01.htm for specific information relating to the ICD-10 codes and the medical policies that are affected.

For additional information about ICD-10 and helpful resources, please visit BCBSNC’s Countdown to ICD-10 Compliance website.
Inter-Plan Programs

BlueCard® Claim Enhancements for Medicare Statutorily Excluded Services

Since January 1, 2006, all Blue Plans, including BCBSNC, are required to process Medicare-crossover claims for services covered under Medigap and Medicare Supplemental products through the Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare claims to the Blue Plan secondary payer eliminating the need for the provider’s office or billing service to submit an additional claim to the secondary carrier. Additionally, this has allowed Medicare-crossover claims to be processed in the same manner nationwide.

As of October 2013, the following Medicare-crossover servicing updates are in place for all Blue Plans to more accurately price and process these claims:

• As of October 13, 2013, providers should submit only those statutorily excluded services by Medicare (i.e., home infusion therapy and hearing aids) to BCBSNC with a GY modifier on each line for the service that is excluded or not covered by Medicare. The GY modifier should be used to indicate that the item or service is statutorily excluded. This will allow BCBSNC to apply the contracted rate with the provider to accurately process the claim according to the member’s benefits. Also, by submitting statutorily excluded services with a GY modifier directly to BCBSNC, you will receive payment for these services in a timelier manner.

• Additionally, when a provider submits a claim to Medicare for services statutorily excluded and not covered by Medicare, but the member has benefits for those services, providers will receive notification via either a paper or electronic remittance advice or letter from the Blue Plan with instructions to submit those statutorily excluded services directly to BCBSNC. Instructions will be similar to the messages below for each format:

  • **For paper remittances:** “This service is excluded or not covered under Medicare. However, the service may be eligible for benefits under other coverage. Please submit this service to your local Plan.”

  • **For electronic remittance advice:** The following HIPAA claim adjustment reason codes and remark codes will be included on the 835 responses:

    • Claim Adjustment Reason Code (CARC) 109: “Claim not covered by this payor/contractor.”

    • Remittance Advice Remark Code (RARC) N837: “Alert: submit this claim to the patient’s other insurer for potential payment of supplemental benefits. We did not forward the claim information.”

    • Group Code: OA

Commonly Asked Questions:

Where do I put the GY modifier on the claim?

The GY modifier should be used with the specific, appropriate HCPCS code when one is available. In cases where there is not a specific procedure code available to describe services, a “not otherwise classified code” (NOC) must be used with the GY modifier.

The GY modifier is located in the line-level procedure code modifier field(s), and the modifier can be:

• Present position 1, 2, 3 or 4

• On the paper 1500 form, the GY modifier can be found in field 24D

• On the paper UB04 form, the GY modifier can be found in field 44

• On the 837P, the GY modifier is found at level 2400, Service Line Loop in SV101-3, SV101-4, SV101-5 or SV101-6

• On the 8371, the GY modifier is found at level 2400, Service Line Loop in SV202-3, SV202-4, SV202-5 or SV202-6

Who do I contact if I have questions?

If you have questions, please call BlueCard® Customer Service at 1-800-487-5522.

(continued on page 6)
Inter-Plan programs updates and reminders
(continued from page 5)

Want to learn more about the Medicare-crossover process?

Note: The following information was shared with providers in September 2012 in an article titled, Duplicate Claims Handling for Medicare Crossover. The article is accessible via the Archives section of the provider portal’s Important News page.

When a Medicare claim has crossed over, providers are asked to wait 30 calendar days from the Medicare remittance date before submitting the claim to BCBSNC.

Providers should continue to submit Medicare-covered services directly to Medicare. Even if Medicare benefits may exhaust or have exhausted, continue to submit claims to Medicare to allow for the crossover process to occur and for the member's benefit policy to be applied.

Medicare primary claims, including those with Medicare exhausted services that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date, will be returned by BCBSNC.

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

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.

- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from BCBSNC. Check the member’s ID card for additional verification.

- Be certain to include the alpha prefix as part of the member identification number. The member ID number of the Blue Plan that is secondary should be included too. The member’s ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, as well as key to facilitating prompt payment of claims.

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

- If the remittance indicates that the claim was crossed over, this means that 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 advice.

- In some cases, the member ID card may contain a COBA ID number. If so, be sure to include that number on your claim.

- For claim status inquiries, contact BlueCard® Customer Service at 1.800.487.5522.

When should I expect to receive payment?

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they are processed first by the Medicare intermediary. The Medicare intermediary process takes approximately 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional business days for you to receive payment or instructions from the Blue Plan. The provider is aware in advance of furnishing services that the person being treated is enrolled in a Medicare Advantage PFFS plan.

What should I do in the meantime?

If you submitted the claim to the Medicare intermediary/carrier and haven’t 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 calendar days from receipt of the Medicare remittance advice.

- Check claims status before resubmitting.

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

(continued on page 7)
BCBSA Announces Blue Distinction® Centers for Cardiac Care

The Blue Cross and Blue Shield Association (BCBSA or Association) added cardiac care facilities to the specialty medical centers that can earn the Blue Distinction® designation for quality of care. Cardiac care joins spine, knee and hip replacement facilities as those eligible to win the Blue Distinction Center (BDC) designation.

The Association has also added a designation for those specialty facilities that provide both high-quality and cost-effective care. Those centers that meet these standards will be recognized as Blue Distinction® Centers+ (BDC+).

While some Blues Plans may choose to award either a BDC or a BDC+ designation for spine surgery, knee and hip replacement and cardiac care, BCBSNC has elected to only recognize BDC+ facilities in North Carolina to support our commitment to reduce cost. In North Carolina, nine hospitals are currently recognized with a Blue Distinction Center+ designation for delivering quality AND cost-effective cardiac care. Hospitals that met the quality measures with the Blue Cross and Blue Shield Association and are interested in receiving the BDC+ designation are encouraged to submit their request for reconsideration, if their costs for the services in question meet the cost criteria.

To receive a Blue Distinction Center+ for Cardiac Care designation, a hospital must demonstrate success in meeting both general quality and safety criteria and cardiac-specific quality measures. These include preventing hospital-acquired infections and having lower rates of complications and death following cardiac surgery and nonsurgical procedures, such as cardiac stent placement. Additionally, the hospitals must show better cost efficiency relative to their peers. Quality is key: Only those facilities that first meet Blue Distinction’s nationally established, objective quality measures will be considered for designation as a Blue Distinction Center+.

With the new Blue Distinction Center Finder, members can find the hospitals that meet these standards and provide high-quality specialty care where and when they need it the most.

Pharmacy News

Update for BCBSNC Commercial Formularies

BCBSNC and its Pharmacy & Therapeutics Committee have reviewed the drug products in the table below and made the following decisions regarding their formulary tier (copayment) placement on the BCBSNC commercial Enhanced and Basic formularies.

The Enhanced formulary consists of four tiers associated with member copayments:
• Tier 1 – Generics (lowest copayment amount)
• Tier 2 – Preferred Brands (second lowest copayment amount)
• Tier 3 – Nonpreferred Brands (second highest copayment amount)
• Tier 4 – Specialty Drugs (coinsurance amount)

The Basic formulary, used for members with Blue Select℠ and Blue Value℠ plans, is a more limited list of covered drugs, and consists of five tiers associated with member copayments:
• Tier 1 – Preferred Generics
• Tier 2 – Nonpreferred Generics
• Tier 3 – Preferred Brands
• Tier 4 – Nonpreferred Brands
• Tier 5 – Specialty Drugs

(continued on page 8)
### Formulary Tier Changes for Brand-Name Drugs

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>ENHANCED (4-tier) Formulary</th>
<th>Therapeutic Class (5-tier) formulary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afinitor® Disperz™</td>
<td>everolimus tabs for susp</td>
<td>Tier 4</td>
<td>Tier 5</td>
</tr>
<tr>
<td>Alendronate</td>
<td>alendronate soln 70 mg/75 ml</td>
<td>Tier 3</td>
<td>Tier 4</td>
</tr>
<tr>
<td>Astagraf XL™</td>
<td>tacrolimus ER</td>
<td>Tier 4</td>
<td>Tier 5</td>
</tr>
<tr>
<td>Auvi-Q™</td>
<td>epinephrine</td>
<td>Tier 3</td>
<td>Non-Formulary</td>
</tr>
<tr>
<td>Diclegis®</td>
<td>doxylamine / pyridoxine</td>
<td>Tier 3</td>
<td>Non-Formulary</td>
</tr>
<tr>
<td>Eliquis®</td>
<td>apixaban</td>
<td>Tier 3</td>
<td>Tier 4</td>
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<tr>
<td>Fulyzaq™</td>
<td>crofelemer</td>
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<td>Non-Formulary</td>
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<td>Giazo®</td>
<td>balsalazine</td>
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<tr>
<td>Invokana™</td>
<td>canagliflozin</td>
<td>Tier 3</td>
<td>Tier 4</td>
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<tr>
<td>Kynamro™</td>
<td>mipomersen</td>
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<td>Non-Formulary</td>
</tr>
<tr>
<td>Liptruzet™</td>
<td>ezetimibe / atorvastatin</td>
<td>Tier 3</td>
<td>Non-Formulary</td>
</tr>
<tr>
<td>Lovaza®</td>
<td>omega-3-acid ethyl esters</td>
<td>Tier 2</td>
<td>Non-Formulary</td>
</tr>
<tr>
<td>Mekinist™</td>
<td>trametinib</td>
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<td>Non-Formulary</td>
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<td>Minivelle™</td>
<td>estradiol patch</td>
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<td>Non-Formulary</td>
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<tr>
<td>Namenda XR®</td>
<td>memantine ER</td>
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<td>Non-Formulary</td>
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<td>Osphena™</td>
<td>ospemifene</td>
<td>Tier 3</td>
<td>Non-Formulary</td>
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<tr>
<td>Oxtellar XR™</td>
<td>oxcarbazepine ER</td>
<td>Tier 3</td>
<td>Non-Formulary</td>
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<td>Pomalyst®1</td>
<td>pomalidomide</td>
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<tr>
<td>Pradaxa®</td>
<td>dabigatran</td>
<td>Tier 2</td>
<td>Tier 4</td>
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<td>Prezista®</td>
<td>darunavir oral suspension</td>
<td>Tier 2</td>
<td>Tier 5</td>
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<td>Procysbi™</td>
<td>cysteamine bitartrate</td>
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<td>Non-Formulary</td>
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<td>Prolensa™</td>
<td>bromfenac 0.07% opthalmic</td>
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<td>Non-Formulary</td>
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<td>Quillivant XR™</td>
<td>methylphenidate ER suspension</td>
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<td>Non-Formulary</td>
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<td>Rescula®</td>
<td>unoprostone opthalmic</td>
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<td>Non-Formulary</td>
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<td>Signifor®</td>
<td>pasireotide</td>
<td>Tier 4</td>
<td>Tier 5</td>
</tr>
<tr>
<td>Simbrinza™</td>
<td>brinzolamide 1% - brimonidine 0.2% ophthalmic</td>
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<td>Non-Formulary</td>
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<td>Suclear™</td>
<td>sodium-potassium-magnesium sulfates / electrolytes</td>
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<td>Non-Formulary</td>
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<tr>
<td>Tafinlar®1</td>
<td>dabrafiban</td>
<td>Tier 4</td>
<td>Non-Formulary</td>
</tr>
<tr>
<td>Tecfidera®1</td>
<td>dimethyl fumarate</td>
<td>Tier 4</td>
<td>Tier 5</td>
</tr>
<tr>
<td>TOBI™ Podhaler™</td>
<td>tobramycin inhalation powder</td>
<td>Tier 4</td>
<td>Tier 5</td>
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<td>Trokendi XR™</td>
<td>topiramate ER</td>
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<td>Uceris®</td>
<td>budesonide DR tablet</td>
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<td>Vascepa®</td>
<td>icosapent ethyl</td>
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<td>Non-Formulary</td>
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<tr>
<td>Vituz®</td>
<td>hydrocodone - chlorpheniramine solution</td>
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<td>Non-Formulary</td>
</tr>
</tbody>
</table>

®Brand names are registered trademarks of their respective owners. ER = extended release. Physician certification/prior review or quantity limits may be required.

*(continued on page 9)*
New Generics Listed on BCBSNC Commercial Formularies

Generic equivalents for the following drug products recently became available. These generic products are available at Tier 1 on the BCBSNC commercial Enhanced formulary. Most new generics are covered at Tier 2 on the commercial Basic formulary. In some cases, a generic equivalent may not be available for all dosage forms or strengths of a specific drug.

Remember to tell your patients that FDA-approved generic drugs 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.*

### New GENERICS

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>ENHANCED (4-tier) Formulary</th>
<th>BASIC (5-tier) formulary</th>
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<tbody>
<tr>
<td>Aricept® 23 mg</td>
<td>donepezil 23 mg</td>
<td>Tier 1</td>
<td>Tier 2</td>
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<tr>
<td>Atacand®</td>
<td>candesartan</td>
<td>Tier 1</td>
<td>Tier 2</td>
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<td>Buphenyl®</td>
<td>sodium phenylbutyrate powder</td>
<td>Tier 1</td>
<td>Tier 2</td>
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<tr>
<td>Campral®</td>
<td>acamprosate</td>
<td>Tier 1</td>
<td>Tier 2</td>
</tr>
<tr>
<td>Comtan®</td>
<td>entacapone</td>
<td>Tier 1</td>
<td>Tier 2</td>
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<tr>
<td>Hepsera®</td>
<td>adefovir dipivoxil</td>
<td>Tier 1</td>
<td>Tier 5</td>
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<td>Lidoderm®</td>
<td>lidocaine patch 5%</td>
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<td>Tier 2</td>
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<td>Luvox CR®</td>
<td>fluvoxamine extended-release</td>
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<td>Metrogel® 1%</td>
<td>metronidazole gel 1%</td>
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<td>Niaspan®</td>
<td>niacin extended-release</td>
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<td>Prandin®</td>
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<td>Prevpac®</td>
<td>amoxicillin-clarithromycin-lansoprazole pack</td>
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<td>Rilutek®</td>
<td>rituximab</td>
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<td>Soriatane®</td>
<td>acitretin</td>
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<td>Temodar®</td>
<td>temozolomide</td>
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<td>Trilipix®</td>
<td>fenofibric acid (choline fenofibrate)</td>
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<td>Vibramycin®</td>
<td>doxycycline suspension 25 mg/5 ml</td>
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<td>Zovirax® ointment</td>
<td>acyclovir ointment 5%</td>
<td>Tier 1</td>
<td>Tier 2</td>
</tr>
</tbody>
</table>

*®Brand names are registered trademarks of their respective owners.

1Listed brand names are for reference only. Brands for which generic equivalents are available are generally covered on the nonpreferred brand tier.

2Physician certification/prior review or quantity limits may be required.

3These new Vicodin trade-name products are available as generics.*
Rx Utilization Management Changes
Effective January 1, 2014

We want to inform you about the following new pharmacy utilization management requirements that will be effective January 1, 2014.

On the medical benefit, the following requirements will apply to commercial and State Health Plan members (does not apply to Federal Employee Program or Medicare Part D members):

Viscosupplements

Members will need to use one of the preferred medications, Synvisc/SynviscOne or Euflexxa, before they can be approved to use one of the nonpreferred medications, which are Hyalgan, Gel-One, Orthovisc, or Supartz. Current and new users will need to submit authorization for the nonpreferred medications.

Tumor Necrosis Factors (TNFs)

A new drug, Simponi Aria, will be added to the list of medications requiring prior approval and quantity limit review. Additionally, Simponi Aria and Remicade will become preferred medications, which means that one of them must be tried first before Rituxan, Ocrenica, or Actemra can be considered for approval. Current users will be grandfathered for this requirement and will not have to use a preferred medication first.

Under the pharmacy benefit, the following requirements will apply to all commercial members who have their pharmacy benefits with us. These changes will not apply to State Health Plan, Federal Employee Program, Medicare Part D members, or for any ASO employer groups that carve out their pharmacy benefits to another pharmacy benefits manager.

Tumor Necrosis Factors (TNFs)

In addition to current requirements for prior review and quantity limits, members must first try two of the following four preferred medications – Enbrel, Humira, Stelara, or Simponi – before they can be approved to use the nonpreferred medications, which are Xeljanz, Cimzia, or Ocrenica. Current users will be grandfathered for this requirement and will not have to use a preferred medication first.

Juxtapid and Kynamro

ALL members will need to obtain prior authorization and quantity limitation approval before using Juxtapid or Kynamro, which are medications used to treat homozygous familial hypercholesterolemia (HoFH).

Vecamyl

ALL members will need to obtain prior authorization before using Vecamyl, which is a medication used to treat moderately severe to severe essential hypertension.

Androgens

The prior review criteria for all androgens will be updated to reflect a change in the requirement of the laboratory testing for the diagnosis of hypogonadism. When submitting a request for one of these medications, please remember that lab values are a required part of this review.

ARBs

Branded Angiotension Receptor Blockers (ARBs) will be added to the restricted access program. This means that the following drugs will be considered nonpreferred medications: Diovan, Azor, Benicar, Benicar HCT, Exforge, Exforge HCT, Micardis, Micardis HCT, Tribenzor, and Twynsta. Members must try a preferred generic ARB prior to receiving any of these nonpreferred ARBs.

The detailed review criteria for these pharmacy utilization management programs are available online at bcbns.com/umdrug.

Summary of 2013 Key Rx Utilization Management Changes

Details regarding BCBSNC Rx Utilization Management changes are made available via our Provider Portal. Provider news items relating to pharmacy utilization management requirements are available by visiting the Important News page at bcbns.com.

Here are some of the key changes in 2013:

Stelara: As of November 1, 2013, NEW users of Stelara who self-inject this medication are required to first try Enbrel or Humira. Users of Stelara prior to the November 1st effective date were grandfathered in and not subject to the new requirement. The current prior authorization requirement and quantity limitations still apply. The new requirement does not apply when Stelara is administered in a provider’s office. Read more...

Bayer and Lifescan glucose test strips: ALL members are required to use Bayer and LifeScan glucose test strips as of October 1, 2013. This new requirement went into effect in April for new test-strip users. As of October 2013, the program applies to all users. Read more...

Zenzedi: Zenzedi (dextroamphetamine sulfate) is an approved medication by the Food and Drug Administration and is available to commercial BCBSNC

(continued on page 11)
Pharmacy News
(continued from page 10)

members. This medication treats ADHD and narcolepsy. As with other similar medications, it will be subject to review for quantity limitations for commercial members who participate in our UM programs. The updated ADHD fax form and criteria is available online at bcbsnc.com/umdrug. Read more...

Liptruzet: Liptruzet is approved by the Food and Drug Administration as a statin medication to lower cholesterol. Liptruzet is a combination of Zetia, which works to lower the absorption of cholesterol, and generic Lipitor, which works to reduce the production of cholesterol. As with our other cholesterol-lowering products, this new medication will require prior review for commercial members who participate in our utilization programs. The detailed approval criteria can be found online at bcbsnc.com/umdrug. Read more...

Xeljanz: BCBSNC requires new patients who are prescribed Xeljanz, which is a new rheumatoid arthritis drug, to try Enbrel or Humira first. The updated fax form is available online at bcbsnc.com/umdrug for your convenience. Read more...

Firazyr (icatibant): Firazyr, a medication used to treat patients with hereditary angiodema, requires prior review when it’s received in the office or outpatient setting and filed under the member’s medical benefit. The requirement applies to ALL commercial and State Health Plan users. Read more...

Reminder: Glucose Strips Unit Increase
The maximum units (or boxes) allowable for CPT code A4253 (blood glucose test or reagent strips for home blood-glucose monitor, per 50 strips) increased from 12 to 20 units/boxes.

Blood glucose test or reagent strips are limited to 20 units/boxes per quarter for patients with insulin-dependent diabetes, and limited to six units/boxes per quarter for patients with noninsulin-dependent diabetes.

The related BCBSNC corporate medical policy was updated to reflect this new allowable limit and is available online for your reference.
State Health Plan

State Health Plan Will Have Split Certificates in 2014

The State Health Plan has awarded the Medicare Advantage business to UnitedHealthcare and Humana for their Medicare-primary retirees for 2014. This means that if the Medicare-primary retiree has a spouse or dependents under the age of 65 covered on their current State Health Plan policy, those family members will have their own individual ID cards with the State Health Plan administered by BCBSNC as of January 1, 2014.

Here are the two split certificate scenarios that you may encounter with your State Health Plan patients beginning in 2014:

- The Medicare-primary family member(s) join UnitedHealthcare or Humana, and the remaining non-Medicare family member(s) remain with the State Health Plan, which is administered by BCBSNC. (Medicare-primary spouses and dependents must follow the election of the Medicare-primary subscriber if all members are 65 or older.)
- The Medicare-primary family member(s) can choose to decline automatic enrollment in the UnitedHealthcare or Humana plans during Open Enrollment in October 2013 and remain with BCBSNC on the traditional 70/30 plan, while the remaining family member(s) move to either the enhanced 80/20 plan or the 85/15 consumer-directed health plan. Remaining family members must all be on the same plan.

Individual ID Cards

With these split certificates, each person (regardless of age) will receive their own ID card. The State Health Plan began issuing individual ID cards for its members, including spouses and dependents, during the July 1, 2013, renewal. These individual ID cards also include the name of any chosen primary care physician or practice.

Effective January 1, 2014, spouses and dependents on a split certificate will be listed as the subscriber on their individual ID cards. It’s important to note that only family members on the same plan type will be included in any family deductible and/or coinsurance accumulators.

Changes for 2014 Blue Options Plan Offerings for State Health Plan

The State Health Plan has a new focus on wellness, which is reflected in its 2014 Blue OptionSM plan offerings. The Basic 70/30 plan stays as it is today, along with a modified Enhanced 80/20 plan with Affordable Care Act (ACA) benefits, and a new consumer-driven health plan (CDHP) 85/15 plan, which also has ACA benefits.

Here are some key highlights for you and your office staff to be aware of when seeing State Health Plan members in 2014:

- The Enhanced and CDHP plans have opportunities for members to reduce their monthly premiums by completing a health assessment, selecting a primary care physician/practice, and attesting to not smoking (or being in a smoking cessation program) during their open enrollment.
- Members who use their selected primary care practice or seek care from designated hospitals or specialists can also benefit from reduced copayments on the Enhanced plan or HRA contributions on the CDHP plan.
- Members can choose the Basic 70/30 plan if they do not wish to participate in one of the new incentive programs with designated providers.
- Specialists (specialty categories for 2014 are general surgery, OB/GYN, gastroenterology, orthopedics, cardiology, and neurology) and hospitals are designated for the State Health Plan when they have met our low-cost AND high-quality benchmarks, or they are designated as a critical-access hospital.
- Practices should be sure to check member ID cards at each visit, as well as check eligibility and benefits for the most up-to-date information. The member’s chosen primary care physician/practice will be listed on the ID card.

Prescription Medical Foods Are Not Covered by the State Health Plan

The State Health Plan does not cover prescription medical foods. Members who take medical foods are responsible for the full cost at a retail pharmacy. Express Scripts® home delivery no longer processes orders for medical foods, and the prescription is returned to the member. Additional details are available in the Important News article dated June 11, 2013.
Blue Medicare News

Reminder: Prime Therapeutics Is the Pharmacy Benefits Manager for Medicare Beneficiaries
Since January 1, 2013, Prime Therapeutics® (Prime) has served as the pharmacy benefits manager for our Blue Medicare HMO and Blue Medicare PPO members. Prime is the same pharmacy benefits manager for BCBSNC’s commercial membership. The original article advising of the expansion to our Blue Medicare HMO and Blue Medicare PPO plans is available for viewing at bcbsnc.com.

Reminder: Echocardiography to Be Added to Blue Medicare Diagnostic Imaging Program
January 1, 2014
BCBSNC added echocardiography services as part of its diagnostic imaging management program for commercial members in January 2012. By adding echocardiography to the program, we’ve helped to ensure that eligible members can receive services that are consistent with recognized best practices. In January 2014, BCBSNC will expand the diagnostic imaging management program for our Medicare Advantage plans (Blue Medicare HMO and Blue Medicare PPO) to include echocardiography services, helping to uphold the same program benefits for our Medicare Advantage members.

BCBSNC’s diagnostic imaging management program is administered by AIM Specialty Health (AIM®), and providers already ordering and providing diagnostic imaging services for BCBSNC’s members will be familiar with program requirements.

Members enrolled in BCBSNC’s Medicare Advantage plans currently require diagnostic imaging prior approval for the following cardiac modalities:
- Myocardial perfusion imaging
- Cardiac CT/CTA
- Cardiac MRI
- Cardiac PET and blood-pool imaging

Effective with dates of service on or after January 1, 2014, prior approval will also be required for Blue Medicare HMO and Blue Medicare PPO members, in advance of the following services being provided:
- Transthoracic Echocardiography (TTE)
- Transesophageal Echocardiography (TEE)
- Stress Echocardiography (SE)

Ordering physicians for Blue Medicare HMO and Blue Medicare PPO members must contact AIM to obtain a prior approval number prior to scheduling an imaging exam for these outpatient services.

Beginning December 16, 2013, ordering providers may begin requesting prior authorization for SE, TEE, or TTE for dates of service on or after January 1, 2014, in one of the following ways:
- Online through BCBSNC’s provider website Blue eSM
- Through the AIM Specialty Health (AIM®) Call Center at 1-866-455-8414

(continued on page 14)
Pre-Exam Questions

Please note that pre-exam questions (PEQs) will be requested for stress echocardiography. Completing the PEQs for these exams will reduce the time it takes to receive your order number.

We believe the changes that we have made to the cardiac imaging program further our objectives of providing a clinically appropriate, consistent and efficient case review process. For more information about our diagnostic imaging programs, visit us on the Web at providers.bcbsnc.com/providers/imaging.faces.

BCBSNC contracts with Aim Specialty Health, an independent entity, to administer the diagnostic imaging management program. Neither BCBSNC nor its agents are affiliated with Medicare.

Collaboration Is Key to Ensuring Timely Decisions Regarding Coverage

It is the expectation of the Centers for Medicare & Medicaid Services (CMS) that a managed care organization and its contracted providers share accountability in ensuring that its members, your patients, receive the services covered by their benefit plans. A large part of that joint accountability involves the exchange of information to determine medical necessity for benefits and ensuring that our members/yours patients do not have needed care or medication delayed as a result of our lack of communication.

It is important that providers collaborate with BCBSNC to ensure our members/your patients receive decisions regarding coverage without delay. When we reach out to you, we commit to asking for only the information we require to make the clinical decision. We will return your calls promptly, and we ask that if we call your office or request additional information via fax that you respond quickly too. When you contact the plan to request a service, please have the clinical information available or include all of it when you fax the request to us. This includes lab and X-ray results, previous treatment information, and in the case of a prescription drug request, we’ll need to know if previous drugs were prescribed or why the drugs on the formulary are not right for this patient.

Our medical policies are located on the BCBSNC external website under Providers/Blue Medicare HMO and PPO: bcbsnc.com/content/providers/blue-medicare-providers/index.htm.

Formularies, criteria and fax forms for prescription drug requests are located at: bcbsnc.com/content/medicare/member/policies/approval.htm

We welcome your feedback and suggestions about how we can improve our communication and processes. Please contact your BCBSNC Strategic Provider Relationships representative with your suggestions.

(continued on page 15)
Protect Your Office and Staff from Exposure to HIPAA Violations

In Chapter 21 of the Blue MedicareSM provider manual, you will find information about how Blue Medicare protects our members’ protected health information (PHI). The provider manual is located at bcbsnc.com/assets/providers/public/pdfs/Provider_Manual.pdf. The information in this chapter on “Privacy and Confidentiality” is even more important now that the Health Information and Technology for Economic and Clinical Health Act (HITECH) was enacted. HITECH includes the final rules, which increase the responsibility of determining whether PHI was compromised when improperly disclosed, and whether we as a health care entity must provide a breach notice to the impacted patient or member. Chapter 21 outlines Blue Medicare’s commitment to maintaining our members’ and your patients’ privacy by incorporating these concepts into our policies. All BCBSNC employees follow these guidelines to avoid breaches of PHI, to ensure that BCBSNC maintains compliance, and to avoid costly, inadvertent disclosures.

When our staff calls a provider and the call goes to voice mail, our privacy policies instruct our staff to leave a generic message if they cannot confirm that the telephone number/voice mail is secure. The inability to leave a more specific voice mail equates to more work, as in most instances because we must attempt to reach your staff again or vice versa. To increase efficiencies in your office and to minimize “phone tag,” it is helpful to note on your voice mail that callers have reached the confidential voice mail of a specific area/department/person or practice. Example: “This is the confidential voice mail of the prior authorization department at XYZ practice.” This would assist both BCBSNC and your staff in getting the information to your office and meeting the needs of patients without delay. Indicating the voice mail is secure or confidential will also increase efficiency in communication and minimize the risk of disclosures. This is a very simple measure that can go a long way in managing member information efficiently, while maintaining their privacy.

References:

Controlling High Blood Pressure in Patients With Diabetes

The American Diabetes Association, the American Association of College of Endocrinology, and the National Kidney Foundation clinical guidelines all agree that the use of an angiotensin converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB) to control high blood pressure in patients with diabetes is first-line therapy. This is due to the clinical benefit of reducing progression of renal and cardiovascular disease in these patients. The Centers for Medicare & Medicaid Services has adopted the use of an ACE inhibitor or ARB in patients with diabetes who have hypertension as a quality measure for Part D health plans.

Despite the widely recognized benefit of this class of drugs, many of our Blue MedicareSM members who have diabetes and hypertension are still not receiving an ACE inhibitor or ARB. The percentage of members with diabetes who have hypertension and are receiving one of these drugs remains lower than the national average*. Underuse of these medications may be due to perceptions of more side effects in the elderly, tolerance for higher than recommended blood pressures in these patients, failure to fill these prescriptions by patients, or all of the above.

Please reevaluate the need for an ACE inhibitor or ARB in your diabetic patients where appropriate. Consider the recommendation to use an ACE inhibitor or ARB as part of any treatment for hypertension in patients with diabetes unless contraindicated. If a change in therapy is necessary, advise your patient directly and send a prescription to the pharmacy.

*Source: 2013 Acumen Patient Safety Reports for BCBSNC and 2014 BCBSNC Star Ratings
High-Risk Medications for Seniors

Are you prescribing high-risk medications to your patients who are over the age of 65? Many of our Blue Medicare members are receiving high-risk medications as part of their routine treatment plan. High-risk medications are those identified by AGS Beers Criteria and by the Pharmacy Quality Alliance that tend to cause adverse drug events in older adults due to their pharmacologic properties and the physiologic changes of aging. According to BCBSNC prescription drug claims, the skeletal muscle relaxants indomethacin and hydroxyzine, are among the most prescribed medications on a list of drugs that should be avoided in elderly patients.

BCBSNC would like to work with our providers to avoid prescribing drugs considered high risk for our members over the age of 65, especially when there may be safer alternatives. Both the Centers for Medicare & Medicaid Services (CMS) and the Healthcare Effectiveness Data and Information Set (HEDIS) have quality measures that focus on decreasing the use of high-risk medications in the elderly. The CMS measure is defined as the percentage of members receiving more than two prescription fills of a high-risk medication. For this measure, a lower percentage is better.

The following sleep medications, non-benzodiazepine hypnotics such as zolpidem, lunesta, or sonata, are also on the high-risk medication list and are recommended for short-term use of less than 90 days due to potential side effects in seniors.

The table below is adapted from information included on the 2012 AGS Beers Criteria of Potentially Inappropriate Medication Use in Older Adults. For a more complete listing, please refer to the website http://www.americangeriatrics.org/.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Concern</th>
<th>Potential Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carisoprodol Chlorzoxazone Cyclobenzaprine Metaxalone Metocarbamol Orphenadrine</td>
<td>Skeletal Muscle Relaxants: Anticholinergic side effects; worsened cognition &amp; behavioral problems (especially in dementia); urinary retention OR incontinence; confusion; sedation; weakness; questionable efficacy (at lower doses)</td>
<td>Non-pharmacologic treatment: Baclofen, tizanidine</td>
</tr>
<tr>
<td>Diphenhydramine, hydroxyzine Older Antihistamines: Anticholinergic side effects; worsened cognition &amp; behavioral problems (especially in dementia); urinary retention OR incontinence; confusion; enhanced sedation</td>
<td>For itching triamcinolone cream 0.025% or OTC emollients For allergic rhinitis: nasal steroid sprays, or low-sedating antihistamines such as levocetirizine or OTC loratadine or cetirizine</td>
<td></td>
</tr>
<tr>
<td>Estrogens</td>
<td>Oral Estrogens: Increased risk of breast and/or endometrial cancer; NOT cardioprotective in older women Oral Estrogens Increased risk of cardiovascular disease, cancer and cancer-related death</td>
<td>Osteoporosis: Alendronate Menopause symptoms: Evaluate appropriateness of ongoing therapy. Use lowest effective dose for the shortest amount of time. Vaginal symptoms: vaginal estradiol (cream, tab, ring); vaginal conj estrogen cream</td>
</tr>
<tr>
<td>Zolpidem, zaleplon, Lunesta Non-benzodiazepine hypnotics Avoid chronic use &gt;90 days</td>
<td>Non-pharmacologic treatment: Sleep hygiene; cognitive behavior therapy</td>
<td></td>
</tr>
<tr>
<td>Indomethacin NSAID Increases risk of GI bleeding/peptic ulcer diseases in hisk risk groups</td>
<td>Non-pharmacologic treatment: Naproxen, ibuprofen, sulindac, Voltaren Gel Colchicine</td>
<td></td>
</tr>
<tr>
<td>Nitrofurantoin Nitrofurantoin: Potentially less effective with compromised renal function. Increased risk of pulmonary toxicity</td>
<td>Trimethoprim/sulfamethoxazole DSCiprofloxacin Trimethoprim</td>
<td></td>
</tr>
</tbody>
</table>
A complete list of high-risk medications and their impact on CMS star ratings can be found on the Pharmacy Quality Alliance website at http://pqaalliance.org/measures/cms.asp.

BCBSNC is committed to providing the most appropriate medications to our Medicare members to enhance their safety. We ask our providers to carefully evaluate whether any of the high-risk medications on this list are still appropriate for your older patients and to consider appropriate alternatives. This may involve a frank discussion with your patients about risks and benefits. As the prescriber, you are the key advocate in helping patients decide which medications they need and which therapies represent the least risk as they age.

Changes to the Blue Medicare™ Rx Standard Plan Formulary for 2014

In 2014, BCBSNC will be changing the formulary offered on the Blue Medicare Rx Standard plan to a new low-cost formulary. This plan is similar in design to many other low-cost plans that are on the market today.

Listed below are some of the features of this low-cost prescription drug plan:

- Significantly fewer drugs will be on this formulary as compared to the 2013 formulary.
- Many generic products are on this formulary, but there is less coverage of brand-name drugs.
- Drugs with safety concerns removed. For instance, combination drugs with more than 325mg of acetaminophen (e.g. hydrocodone 5mg/acetaminophen 500mg).
- Drugs considered high risk when taken by older patients were removed or placed in the non-preferred brand tier, regardless of product type, and may have prior authorization requirements.
- Only generic drugs with low drug costs were included on tier 1.*
- Extremely high-cost generics (> $300/script) or drugs with safety concerns were moved to non-preferred brand tier 4.

BCBSNC will be contacting the members on this plan who are impacted by the formulary changes by letter and by phone.

Additional communication about these formulary changes will be included in the Annual Notice of Change. Our normal transition process will be applied at the beginning of the year for coverage of medications until the member can discuss other medication options with their provider.

*In 2014 tier 1= Preferred Generic Drugs tier 2= Nonpreferred Generic Drugs tier 3 = Preferred Brand Drugs tier 4= Nonpreferred Brand Drugs tier 5 = Specialty Drugs

Providers Play an Important Role in Ensuring BCBSNC’s Commitment to Compliance

BCBSNC is required by CMS to maintain and administer a compliance program and a program to fight fraud, waste and abuse (FWA). CMS advises that the seven basic elements of the compliance program include:

- Maintaining written policies and standards of conduct
- Instituting high-level oversight, led by a compliance officer
- Providing effective training and education about Medicare program requirements
- Providing effective and accessible lines of communication between the compliance officer, employees, and first tier, downstream, and related entities (FDRs)
- Ensuring that disciplinary standards are well-publicized
- Performing routine monitoring, auditing and identification of compliance risks
- Establishing procedures for prompt response to compliance issues.

BCBSNC ensures that these elements are met in the following ways:

- We provide our BCBSNC Code of Ethics and Business Conduct on our website at bcbsnc.com, where we maintain an electronic library of policies, including a written ethics and compliance program.
- BCBSNC has a compliance officer and a formal committee structure to provide oversight responsibilities for compliance.
- BCBSNC provides annual training to its employees, its board of trustees, and sales agents on training topics including: the BCBSNC Code of Conduct, Fraud,
Waste and Abuse, and Medicare Compliance. (As stated in Chapters 9 of the CMS-issued Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual) Providers, vendors, and other business partners who have met the Fraud Waste and Abuse training through enrollment in Part A or B of the Medicare program, or through accreditation as a supplier of DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies), are deemed to have met the FWA training and education requirements for BCBSNC.

- BCBSNC offers several options for employees, producers and subcontractors to report issues or ask questions, either directly or via anonymous hotlines, or related online reporting tools. If there is suspected fraud, waste or abuse, please contact the Special Investigations Unit (SIU) at 1-800-324-4963. If there are concerns about the actions of a BCBSNC employee, please contact the BCBSNC Ethics Hotline at 1-888-486-1554.

- Consequences for BCBSNC employees who violate the BCBSNC Code of Conduct or the FWA policy are clearly communicated through our internal Code of Ethics and Business Conduct policy, and through annual employee-required training courses.

- BCBSNC monitors hotline reports for trends, analyzes claims data to identify fraud, and reviews key CMS compliance metrics. BCBSNC also performs risk assessments, executes audit plans, and conducts subcontractor oversight.

- BCBSNC has written processes in place to investigate issues, track them to completion, and report matters to government entities when necessary.

Due to BCBSNC’s relationship with CMS, Blue Medicare℠ participating providers should be aware of several key federal rules:

- **Anti-Kickback Statute** - This statute imposes criminal penalties for individuals or entities who knowingly and willfully offer, pay, solicit, or receive remuneration to induce or reward business reimbursement in federal health care programs.

- **False Claims Act** - This act imposes liability on any person of an organization who submits a claim to the federal government that is known or should be known to be false.

- **Excluded Entity Provision of Social Security Act** - Medicare Part C and Part D contractors are prohibited from employing or contracting with an individual or entity who is excluded from participation in federal health care programs.
Blue Medicare News
(continued from page 18)

BCBSNC Prior Authorization Requirements May Differ for Blue Medicare HMO and PPO Members

We’d like to remind participating providers that services listed on the BCBSNC prior authorizations or prior approval list require that primary care physician, authorized specialist, or other provider of service, must contact BCBSNC Care Management & Operations—Medicare C/D at 1-888-296-9790, Monday through Friday, 8 a.m. - 5 p.m. EST to obtain prior authorization for Blue MedicareSM members.

The prior authorization list and related guidelines for Blue Medicare HMO and Blue Medicare PPO are available online for your convenience. This includes prior authorization information for admissions and private duty nursing, diagnostic imaging services, prescription drugs, and other services or procedures (i.e., home health care, durable medical equipment, or mental health services) are on bcbsnc.com for your reference and convenience.

BCBSNC should be notified within 24 hours or the first business day after an admission is required following an urgent/emergency admission. Home health or durable medical equipment services arranged on a weekend or after business hours will be authorized the next business day, if appropriate medical justification is met and participating vendors are used for the services in question.

Reminder: Updates to Blue Medicare HMO/PPOSM Medical Coverage Policies Available Online

Care Management & Operations and Medicare C/D provide online access to Blue Medicare HMO/PPO medical coverage policies along with applicable CPT/HCPCS codes. The medical coverage policies are developed after review of current Centers for Medicare & Medicaid Services national coverage determinations/local coverage determinations, standard of care literature/research, and recommendations from physician specialists. Updates to the medical coverage policies and corresponding codes are available on the BCBSNC external website at bcbsnc.com/content/providers/blue-medicareproviders/medical-policies and bcbsnc.com/assets/services/public/pdfs/bluemedicare/prior_approval/cpt_codes.pdf.

Making Decisions About Appropriate Care and Service

BCBSNC and its associated delegates require practitioners, providers and staff who make utilization management decisions to make those decisions solely based on appropriateness of care, and service and existence of

(continued on page 20)
Blue Medicare News
(continued from page 19)

coverage. BCBSNC does not compensate nor provide any other incentives — to any practitioner, or other individual conducting utilization management review — to encourage denials. Remember, no compensation or incentives are in any way meant to encourage decisions that would result in barriers to care or service, or underutilization of services.

Finding an Interpreter

In North Carolina, providers can locate an interpreter to assist in communicating with Spanish-speaking patients (and patients speaking other foreign languages) 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. Find contact information for translators and interpreters within North Carolina at http://www.catiweborg/index.htm.
Updates and Reminders

Be In the Know – Visit Our Important News Page Today!

The provider’s Important News page is your source for the latest news and updates that may impact your business. It’s your one-stop-shop for information relating to claims processing, member health benefits, prior authorizations, medical policy changes, and more. This section of the newsletter highlights some of the latest breaking news. To view a complete listing of our news articles, simply visit us online at bcbsnc.com/providers.

Privacy Regarding Member Self-Paid Services or Items

BCBSNC is committed to protecting the privacy of our member’s medical and personal information. Under recently updated HIPAA privacy regulations, a member may pay the total cost of a medical service or services and request that a provider keep information about that service or services confidential. In these instances, providers are required to abide by the member’s request and not submit a claim to BCBSNC for the specific service(s) in question.

Under current regulations, providers may collect the cost of a service or supply provided to a member from that member, if the member requests nondisclosure of his or her protected health information to BCBSNC, and provided the member is personally paying for the costs out of pocket for such a service or supply.

Unless otherwise permitted by law or regulation, the amount charged to the member for a service or supply may not exceed the BCBSNC allowed amount for that particular service or supply.

Additionally, providers are not permitted to (i) submit claims related to, or (ii) bill, charge, seek compensation, remuneration, reimbursement, or collection from BCBSNC for services or supplies provided to a member, if the member has requested that no claim be submitted to BCBSNC and the member is paying for the charge out of pocket.

Please note that withholding claims and billing members for unfiled services and supplies is allowed only when requested by the member for the member’s own privacy and confidentiality.

Prior Review and Certification Requirements

Providers and facilities participating in the BCBSNC network are responsible for ensuring that prior review and certification approvals are obtained (when applicable) in advance of providing non-emergency services, even when a member has Medicare as their primary coverage and BCBSNC as the secondary plan. This includes all services on the BCBSNC prior plan approval list, inpatient hospital admissions, and admissions to non-Medicare-certified skilled nursing facilities. Read more...

To request prior review/certification requests: call Healthcare Management & Operations at 1.800.672.7897.

To obtain the most recent prior review list:
- Visit our website at bcbsnc.com/providers
- Contact Healthcare Management & Operations at 1.800.672.7897.
- Log-in to our internet-based application, Blue eSM.
Reminder: BCBSNC System Edits Apply Correct Coding Guidelines for CPT, HCPCS, and ICD-9 Diagnosis and Procedure Codes

BCBSNC reserves the right to implement system edits to apply correct coding guidelines for CPT, HCPCS, and ICD-9 diagnosis and procedure codes. System edits are in place to enforce and assist in a consistent claim review process. The coding edits reflect BCBSNC medical coverage guidelines, benefit plans, and/or other BCBSNC policies. Unbundling, mutually exclusive procedures, duplicate, obsolete, or invalid codes are identified through the use of coding edits.

Revisions to the HCR Preventive Services Coding Guide

BCBSNC released the Health Care Reform Preventive Services Coding Guide to providers in June. As new national recommendations are published, we will update the online guide accordingly.

The October 1, 2013, revisions include:

- ICD-10 diagnosis codes added. Please note that although the codes will not be effective until October 1, 2014, the revision was made now to assist providers with modifying forms and processes to reflect the extensive coding changes that will be required on all claims next year.
- “In-network pharmacy” was removed from all over-the-counter drug coverage statements.
- The “contraceptive methods and counseling” section was revised. The age limitation was removed, and additional covered contraceptive products are now included.
- The ICD-9 V codes range selection is now included in the vaccine section, along with a coding example.

Providers can view these latest revisions by accessing the guide via Blue eSM under the “Related Links” section.
Federal Employee Program

FEP Migration to the Power MHS System

BCBSNC’s transition of the claims processing system for the Federal Employee Program (FEP) from our Legacy system to our Power MHS system allows us to provide better service, expedite claims transactions, improve accuracy, and reduce the costs associated with the many manual processes required for FEP claims processing on the older system.

The following enhancements are a result of the transition:

• The Explanation of Payment (EOP) has the same, familiar look as the EOP for our commercial lines of business (i.e., clearer descriptions on column headers, enhanced remark codes with easy to understand descriptions).

• Improvements to claim processing accuracy by utilizing current Power MHS code editing systems to assist in evaluating the accuracy of submitted CPT and HCPCs codes.

• Improved consistency and predictability by applying the existing BCBSNC policies and procedures relating to products on Power MHS to FEP. The medical policies that apply to FEP were not be removed as a part of the migration, but the claims editing, bundling, reimbursement policies, and other provider-related policies associated with our other products on Power MHS now apply to FEP instead of those policies and procedures specific to Legacy.

• Participating providers enrolled for electronic funds transfer (EFT) no longer have to wait for their manual checks to arrive in the mail – BCBSNC electronically transfers funds directly into your account. Please see the Important News article titled, Electronic Funds Transfer Available for FEP Business in Early October for additional information regarding EFT availability.

It is important to remember that although pricing is determined based on current Power MHS coding and system edits, claim submissions are adjudicated in the claims management system for the Federal Employee Program. The FEP claims management system contains membership data, applies benefits, stores claims history, adjudicates claims, and provides payment information to generate checks, EOPs and EOBs.
Global Maternity and Multiple Births Billing Guidelines

A quick reference guide outlining BCBSNC's Global Maternity and Multiple Births Billing Guidelines is now available online for your reference and convenience on our provider portal at bcbsnc.com/providers. The guide can also be accessed from the “Training Guides” section of our provider “Education and Learning Center” page.