Welcome to BCBSNC…

2013 Total Access Provider Training

2nd Quarter
Today’s Agenda

- Introductions
- Provider Web Portal
- Electronic Solutions
- Operational Updates
- Latest Provider News
- 2013 Benefit Changes
- Blue Value and Blue Select
- Provider Education
- ICD-10 Readiness
- Provider Tools
- Conclusion & Resources
- Time
Provider Portal

Have you visited us on the Web lately?

Provider Portal highlights include:

+ **Provider newsletters** – BlueLink and Blue Medicare
+ 24/7 virtual provider **e-learning center**
+ Interactive provider **forms, documents** and **manuals**
+ Quick access to **BlueCard**, **Blue Medicare**, and **Dental Blue** information

Check it out and take a tour!
Important News –
Be in the know

Stay up-to-date by visiting us on the Web at: www.bcbsnc.com/providers
Provider Newsletters
BlueLink and Blue Medicare

BlueLink
News from Blue Cross and Blue Shield of North Carolina

Vol. 18, Iss. 2
Spring/Summer 2012

Inside:
- Highlights and Accomplishments
- Pharmacy News
- News and Updates for Blue Link
- VBHC Programs
- Updates and Reminders
- Blue Health News
- BlueLink Updates and Reminders

Provider Newsletters
BlueLink and Blue Medicare

Provider Newsletter
Spring/Summer 2012
A publication for providers participating in the BlueCross and Blue Shield of North Carolina Blue Cross Blue Shield HMO and Blue Medicare PPO products

High Risk Medication in the Elderly

Blue Cross and Blue Shield of North Carolina (BCBSNC) in its commitment to improving the quality of care among our Medicare members. We ask that you, our healthcare providers, join us in efforts that decrease unnecessary use of high-risk medications (HRMs) in the elderly.

We recognize that each patient is unique, and that medication decisions must be made on an individual basis. So, in each encounter you have with a Blue Medicare member, we ask you to carefully evaluate the indication of any medication, whether the medication still has a benefit and if a safer alternative may be substituted. Remember, an acceptable indication of a drug for Medicare patients is particularly important when providers service Blue Medicare HMO and Blue Medicare PPO members carefully evaluate whether it is appropriate to use an HRM. The use of HRMs in the elderly is an NCQA, NCBS, and CMS quality measure. This measure is adapted from the Medicare measure known as Drugs to Be Avoided in the Elderly (DAB). The DAB measure identifies the percentage of older adults (over age of 65) who receive medications considered to be a potential high risk for an adverse drug-related event. Blue Cross Blue Shield plans that include drug benefits are subject to DAB performance measures. The resultant data ratings from CMS. Additional information relating to DAB performance measures and their impact on CMS data ratings can be found at the Pharmacy Quality Alliance website at www.pqaalliance.org.

Muscle relaxants and anticholinergics are included in the list of HRMs. These medications are prescribed to the Blue Medicare population, and the risk of prescribing for these drugs is higher in North Carolina than the national average. A list of HRMs prescribed in the Blue Medicare population can be found on the NCQA HEDIS website at www.ncqa.org/Portals/96/Neurology/HCUP/HCUP-DAB-Avoid_Elderly.pdf

The HRMs list of DAB is based on the DAB criteria – first released in 1997 and revised for Blue Medicare HMO who developed this guidance for using medications in the elderly. The updated 2012 DAB criteria were recently published by the American Geriatrics Society (AGS), listing medications that pose a high risk of side effects and are potentially inappropriate for reasons due to age-related changes. Please review the information in the DAB criteria and the recommendations for safer alternatives for elderly patient available on the AGS website at www.americangeriatrics.org.

The AGS Foundation for Health in Aging has published a printable pocket version of the DAB criteria and a Teen Medications Older Adults Should Avoid or Use with Caution zip code.

If you have questions about HRMs or the recommended safer alternatives to those medications, please refer to the website references previously listed in this article or contact BCBSNC at 1-877-670-9667 ext. 7872.

Don’t miss out!
To receive future editions of the newsletter, join our email registry by visiting us online at www.bcbsnc.com/providers.

BlueCross BlueShield of North Carolina
Get the Latest News

Join our email registry for the latest news, policy changes, online course offerings and more.

Register Now

Provider Email Registry

Complete the form below to be added to our mailing list and get the latest updates from BCBSNC.

Name:

Company Name:

Email:

- HTML
- Text

- Subscribe
- Unsubscribe

Submit

This is an opportunity for you to receive real-time BCBSNC news and updates sent directly to you via email – sign-up today using the Register Now link on the Provider home page at www.bcbsnc.com/providers.
Electronic Solutions
Features of Blue e

https://providers.bcbsnc.com

Internet based application for:

- Eligibility verification
- Claim status
- UB04 & CMS-1500 claim entry including corrected claims
- Claim denial listings
- Remittance inquiry (EOP) detail for all lines of business
- Electronic Fund Transfer enrollment
- Self guided training via online computer based training modules
- Resources
Sign up for Blue e is easy!

+ In order to utilize Blue e, providers must have a registered NPI with BCBSNC.
+ Complete the Blue e Interactive Network Agreement online.
+ After your completed forms are received, eSolutions will process your setup request.
+ An eSolutions analyst will then contact you via email to provide you with your User ID and password, and instructions to utilize the system.
+ You can expect to be using Blue e within two weeks of our receipt of the completed Interactive Network Agreement.
Our Focus

+ Collaborate with our provider community to provide quality health care services at a reasonable cost
+ Reduce administrative costs for providers and BCBSNC
+ Increase efficiencies through e business tools
+ Provide accurate and concise educational updates to providers
Electronic Resources

+ **Online tools** –
  - Blue e application
    - [http://www.bcbsnc.com/content/providers/index.htm](http://www.bcbsnc.com/content/providers/index.htm)
  - HealthTrio
    - [https://www.healthtrioconnect.com/app/index.page](https://www.healthtrioconnect.com/app/index.page)

+ **Web site resources**
HIPAA transactions

+ 837 claims, 835 remittances, 270/271 eligibility inquiry/response, 276/277 claim status inquiry/response

Companion guides for all HIPAA transactions are located on our web site at [www.bcbsnc.com/providers/esolutions/hipaa](http://www.bcbsnc.com/providers/esolutions/hipaa)

- Provides detail transaction information i.e. loop, segment
- Assists providers in determining reason for rejection
- Can be shared with clearinghouse vendors to resolve issues
Blue e Homepage
To Verify Benefits – click Eligibility
Please enter the member number and/or the member last name, first name, and date of birth. A member number is required to search for FEP or out-of-state members. You may enter a single date for the date of service, or if left blank, it will search on today's date.

* Required fields

**Provider Number**

**Member Number**

Ex: YPP000000000

**Member Last Name**

**Member First Name**

**Member Date of Birth**

Ex: MMDDCCYY

**Date of Service**

Ex: MMDDCCYY

Search
Health Eligibility

Eligibility for 01/01/2009 - 12/31/9999

Member Information

Member Number:
Name:
Address:

Date of Birth:
Sex: Female
Rel. to Subscriber: SUBSCRIBER

Policy Information

Product: BLUE OPTIONS HSA - GROUP
Group Number: 009424
Group Name: BLUE CROSS AND BLUE SHIELD OF
Insurance Type: BLUE OPTIONS HSA - GROUP-Self-insured Group

Effective Date: 01/01/2009
Paid Through/Term Date: 12/31/9999
# Member Liability Summary

## In-Network

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoInsurance</td>
<td>n/a $3000.00</td>
<td>$3000.00</td>
</tr>
<tr>
<td>Deductible</td>
<td>$3000.00</td>
<td>$2278.58</td>
</tr>
<tr>
<td>Out-Of-Pocket</td>
<td>$6000.00</td>
<td>$5278.58</td>
</tr>
</tbody>
</table>

## Out-of-Network

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoInsurance</td>
<td>n/a $6000.00</td>
<td>$6000.00</td>
</tr>
<tr>
<td>Deductible</td>
<td>$6000.00</td>
<td>$6000.00</td>
</tr>
<tr>
<td>Out-Of-Pocket</td>
<td>$12000.00</td>
<td>$12000.00</td>
</tr>
</tbody>
</table>

**COB Information:** No other insurance information on file.

**Additional Information:**
No Pre-existing Condition Waiting Period
Remember, the benefits you see on this screen are a summary of member benefits and do not indicate payment when a claim is filed.

- Abortion
- Ambulance
- DME
- Dental Services
- Diagnostic Services
- Emergency/Urgent Care
- General Benefit Information
- Home Health/Hospice
- Hospital Services
- Infertility/Sexual Dysfunction
- Maternity/Newborn
- Mental Health/Substance Abuse
- Nursing Care
- Pharmacy
- Physician Services
- Preventative/Wellness
- Rehab/Therapy Services
  - Occupational Therapy

**Physical Therapy/Occupational Therapy INDIVIDUAL**

**COVERAGE LIMIT - UNIT**

**Benefits Usage:** VISITS: 30; 30 remaining for SERVICE YEAR
Claim submission via Blue e - Claim Entry

- CMS1500 and UB04 claim entry
- Member demographic data pre-filled using Member ID supplied

To Add Claim, select a provider number and enter a member number.
To Retrieve a Claim, select a provider number and enter a claim number OR a member number.
To view a Claim or Error Listing, select a provider number and click the applicable button.

To clear all pre-populated fields, click the Clear button.

*Required Field

*Provider Number: 
Member Number: 
Claim Number: 

Add a Claim  View Claims Listing  View Error Listing  Retrieve a Claim
CMS-1500 Submission through Blue e

- **Primary Claims**
- **Corrected Claims** – requires indication via drop down box at top of form

![CMS-1500 Form Image]

UB-04 Submission through Blue e

- **Primary Claims**
- **Corrected Claims** – indicated by bill type
- **Secondary Claims** – indicated by bill type
837 Denial Listing

- Allows the provider to identify rejected claims that need correction and resubmission.
## BCBSNC 837 Claim Error Listing

<table>
<thead>
<tr>
<th>Date Of Report</th>
<th>All Edit Errors</th>
<th>Implementation Guide Errors</th>
<th>BCBSNC Edit Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number Of Claims</td>
<td>Charges Of Claims</td>
<td>Number Of Claims</td>
</tr>
<tr>
<td>09/21/2009</td>
<td>8</td>
<td>$3,297.00</td>
<td>0</td>
</tr>
<tr>
<td>09/22/2009</td>
<td>1</td>
<td>$120.00</td>
<td>0</td>
</tr>
<tr>
<td>09/23/2009</td>
<td>5</td>
<td>$5,329.00</td>
<td>0</td>
</tr>
<tr>
<td>09/24/2009</td>
<td>2</td>
<td>$1,009.00</td>
<td>0</td>
</tr>
<tr>
<td>09/25/2009</td>
<td>2</td>
<td>$498.00</td>
<td>0</td>
</tr>
<tr>
<td>09/28/2009</td>
<td>11</td>
<td>$2,856.00</td>
<td>0</td>
</tr>
<tr>
<td>09/29/2009</td>
<td>1</td>
<td>$12,174.80</td>
<td>0</td>
</tr>
<tr>
<td>09/30/2009</td>
<td>3</td>
<td>$500.00</td>
<td>0</td>
</tr>
<tr>
<td>10/01/2009</td>
<td>18</td>
<td>$18,763.00</td>
<td>0</td>
</tr>
<tr>
<td>10/02/2009</td>
<td>3</td>
<td>$2,878.00</td>
<td>0</td>
</tr>
</tbody>
</table>
Claim Status

• Available for BCBSNC, FEP, Medicare Supplemental and Inter Plan Program (Blue Card members)
• Provides link to the EOP
• Has line level detail for professional claims
Claim Status Display

**Claim Status Detail for: 808697808697**

- **Member:** Victoria Blue-Shield
- **Member No.:** YPPW0000000
- **Product:** BLUE OPTIONS
- **Patient Account Number:** 401280844012808
- **Diagnosis Code:** 784.0
- **Medical Record Number:** 936989369
- **Place of Service:** 22
- **Claim Reference Number:** 00123456789101

**Claim Status: Finalized**

**Timeline**

- **Date of Service Start:** 01/05/2009
- **Date of Service End:** 01/09/2009
- **Received Date:** 01/14/2009
- **Check Payment Date:** 01/20/2009

**Payment Information**

- **Billed Charges:** $853.00
- **Contracted Charges:** $853.00
- **NCGS Interest Paid:** $0.00
- **Deductible Amount:** $0.00
- **Coinsurance Amount:** $0.00
- **Copay Amount:** $0.00
- **Amount Paid:** $503.27
- **Check Number:** 3826690
Clear Claim Connection (C3)
What C3 Is

+ C3 is a tool that indicates only: 1) how combinations of codes (including modifiers) will be bundled and/or unbundled; and 2) whether the codes are in conflict with the age and gender information that is entered.

What C3 Is Not

C3 does not take into account many of the circumstances and factors that may affect adjudication and payment of a particular claim, including, but not limited to, a member’s benefits and eligibility, the medical necessity of the services performed, the administration of BCBSNC’s utilization management program, the provisions of the Provider’s contract with BCBSNC, and the interaction in the claims adjudication process between the services billed on any particular claim with services previously billed and adjudicated.
Select the C3 edition based on the date the claim processed.
Claim Entry

Gender:  ○ Male  ○ Female
Date of Birth: 01/01/1980 (mm/dd/yyyy)

Select radio button for gender. Enter date of birth.

Enter procedure codes & modifier. Enter dates, or Tab through to default today's date.

Click here if more than 5 procedures.

Click on Review Claim Audit Results button after all procedures have been entered. Click Clear button to reset screen.
To review Clinical Edit Clarification, click anywhere on the grid line with a Recommended action of either “Disallow” or “Review”. Then click on the Review Clinical Edit Clarification button.

<table>
<thead>
<tr>
<th>Recommend</th>
<th>Procedure</th>
<th>Date of Service</th>
<th>Description</th>
<th>Modifiers</th>
<th>RVU</th>
<th>Pay %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allow</td>
<td>99201</td>
<td>06/27/2012</td>
<td>OFFICE/OUTPATIENT VISIT NEW</td>
<td>1.22</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Allow</td>
<td>80061</td>
<td>06/27/2012</td>
<td>LIPID PANEL</td>
<td>0.00</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td><strong>Disallow</strong></td>
<td>36415</td>
<td>06/27/2012</td>
<td>ROUTINE VENIPUNCTURE</td>
<td>0.00</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
User may return to Review Claim Audit Results page, return to Current Claim Entry page, or begin a New Claim.

Printable version link eliminates header and web information.

Number of Edits or Clarifications

Response:

Procedure 80061 is used to report a lipid panel. This panel must include serum cholesterol (82465), HDL cholesterol (83718), and triglycerides (84478).

Procedure 36415 is used to report the insertion of a needle into a vein or into the skin for the purpose of withdrawing a sample of blood for analysis or testing. This procedure is a necessary step in obtaining a sample of blood for analysis and, in most cases, is performed by a technician or a nurse.

Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.

"Health Plan Policy (HPP)" edits are sourced to a specific benefit, medical or payment policy. Health Plans concur that these edits edit are consistent with current health plan policies.

Venipuncture is an integral step in performing any laboratory analysis of a patient’s blood or serum. The method of obtaining the sample is integral to performing the laboratory analysis when reported by the same provider. Historically, inpatient laboratory services included specimen acquisition and handling as an inherent component of the laboratory charge. More recently, some health plans now follow CPT guidance that specimen acquisition and handling are distinct service components from the analytic service performed. The CPT Assistant (December 2008) states, "The collection of the specimen by venipuncture is not considered an integral part of the laboratory procedure performed. If both the collection of the specimen(s) by venipuncture and the laboratory procedure(s) are performed, then it would be appropriate to report a code for the collection of the specimen(s) in addition to the appropriate code(s) from the 80000 series for the laboratory procedure(s) performed." Nevertheless, many health plans still set fee schedules for laboratory services that include the phlebotomy charges in the global laboratory service. In such circumstances, edits that deny the phlebotomy service apply - based on the applicable health plan payment policy or business agreements. Please note: CPT guidelines are considered during the edit development process; however, their presence does not guarantee incorporation within the code auditing logic. CPT is a reporting tool; as stated in the Introduction to the CPT Manual, "Inclusion or exclusion of a procedure [in this manual] does not imply any health insurance coverage or reimbursement policy."
Additional Blue e Features
The *What's New* feature on the Blue *e* home page provides informative bulletins, tips, and other new information relating to Blue *e*. You can access these messages by clicking on a hyperlink in the *What's New* section at the top of the Blue *e* home page. Clicking the "View All Articles" hyperlink takes you to the What's New Archive page where you can view past articles.

- **Note:** The green "New!" text indicates that the story was added within the last 14 days.
Ancillary Claims Filing BCBSNC Requirements
06/21/2012

Effective October 14, 2012, Blue Cross and Blue Shield of North Carolina (BCBSNC) will make changes to our claims processing system, which will automate claim filing requirements for Ancillary Providers and some providers may see changes in where their claims are processed.

Please see the attachment for the ancillary claim filing guidelines.

Ancillary Claims Filing – BCBSNC Requirements

Claim status and Eligibility inquiry responses
06/13/2012

The Department of Health and Human Services (HHS) has adopted the CAQH CORE Phase I & II Operating Rules as part of the Affordable Care Act related to Operating Rules for Health Care Eligibility/Benefit Inquiry and Response (270/271), as well as Claim Status Inquiry and Response (276/277). The mandated implementation date is by January 1, 2013.
Fee Schedules via Blue e for MD Providers

Please submit all the required data. Please select either one code, a range of codes, or the entire fee schedule for review.

- **Provider Number:**

- **Choose a Network:** [Select One]

- **Find:**
  - Specific CPT or HCPCS Code: 
    - Example: 12345
  - Range of CPT or HCPCS Codes
    - Up to 100 codes: 
      - Example: 12345 to 12348
  - Entire Fee Schedule (PDF)

Please Note: The entire fee schedule is very large and may take a few minutes to generate and download.

---

**Please Note:**
The Fee Schedule Information provided is proprietary, confidential and a trade secret. The presence of a code or allowable amount on a fee schedule does not guarantee payment of the displayed amount or issuance of a member's benefits. For more information, please review your Provider Agreement or visit our Blue Book Provider eManual located on the provider web page. The Fee schedule information displayed applies to "MD" specialty only.
The Fee Schedule Display page can show up to 100 codes per fee schedule. If you have an additional fee schedule, based on place of service, values for the second fee schedule appear after the first. Scroll down through the display page to see the values for the second fee schedule.

If you have requested an entire fee schedule, the Display page opens to a Acrobat Adobe PDF. To return to the transaction, click on the Fee Schedule hyperlink at the top, right corner of the page.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Modifier</th>
<th>Contracted Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>10060</td>
<td>INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENITIS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15999</td>
<td>UNLISTED PROCEDURE, EXCISION PRESSURE ULCER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16036</td>
<td>ESCHAROTOMY; EACH ADDITIONAL INCISION (LIST SEPARATELY IN ADDITION)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17999</td>
<td>UNLISTED PROCEDURE, SKIN, MUCOUS MEMBRANE AND SUBCUTANEOUS TISSUE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19102</td>
<td>BIOPSY OF BREAST; PERCUTANEOUS, NEEDLE CORE, USING IMAGING GUIDANCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19103</td>
<td>BIOPSY OF BREAST; PERCUTANEOUS, AUTOMATED VACUUM ASSISTED OR ROTAT...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19295</td>
<td>IMAGE GUIDED PLACEMENT, METALLIC LOCALIZATION CLIP, PERCUTANEOUS, ...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19499</td>
<td>UNLISTED PROCEDURE, BREAST</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Blue e Training and Help

Related Links
- Important Provider News
- Prior Plan Approval (PPA) List
- Out of state member Medical Policy/Pre-cert/auth
- ePrescribe for online prescriptions
- Medicare Advantage Private Fee for Service Plans
- Electronic Funds Transfer (EFT) Registration Form
- Dental Blue Select
- BCBSNC eSolutions Website
- BCBSNC.com Specifically for Healthcare Providers
- Provider Refund Return Form
- Coordination of Benefits Questionnaire
- Care Gap Change Request Form

Helpful Links

Computer-Based Training (CBT's)
Spotlight: E Mail the Blue e Helpdesk!

The Blue e Help Desk is available to answer your questions about Blue e via e-mail. A Help Desk analyst will respond to your e-mail within two business days.

Click on one of the hyperlinks below to identify the area of your problem. Please include: 1.) a detailed description of your problem/question, 2.) the transaction in Blue e, 3.) your User ID, 4.) NPI, 5.) the date and time of your issue, 6.) any other information that would help us research your issue.

Click on a subject/topic below to send an email:

- Administration
- Billing
- Eligibility
- Health Management
- Other Blue e General Issues

If you have difficulty launching an email from this page, send an email to Bluee.HelpDesk@bcbsnc.com.

BCBSNC uses encryption to enhance the security and privacy of confidential email. In order to receive emails from BCBSNC that contain PHI or other confidential data, you will be required to create an account and password with Voltage.

Please refer to the SecureMail User Guide for more information

👩‍💼 Secure Mail Recipient Guide
HealthTrio

+ Web portal connecting providers to BCBSNC Medicare Advantage members’ eligibility and claims information
  ▪ Applicable for Medicare PPO<sup>SM</sup> and Blue Medicare HMO<sup>SM</sup>

+ With HealthTrio, providers can:
  ▪ Verify member eligibility and benefits information
  ▪ Verify provider information
  ▪ Check claim status

+ Registering for HealthTrio
  ▪ Go to www.healthtrioconnect.com
  ▪ Select the link for Providers to register.
  ▪ Print, complete, and fax the last page of the document accessed via the Print Security Agreement hyperlink to the fax number on the form.
  ▪ Activation will not be enabled until the security agreement is received
HealthTrio Connect Registration

connect Sign In

User ID

Password

Sign In | Forgot your password?

Customer Service

Email Customer Service

Help

1-877-814-9909

New User Registration

Provider

Employer

Broker

Member

Visitor Sign In

Unauthorized use of this system is strictly prohibited and will be prosecuted to the fullest extent of the law.

Copyright © 2012 Healthtrio LLC. All rights reserved. VPAT | Privacy Policy | System Requirements
Please choose the Health Plan you are registering a provider for.

Health Plan

- Select a Health Plan
- Blue Cross and Blue Shield of Vermont
- BlueCross BlueShield of NC
- Bright Health Physicians
- Capital Health Plan
- CareOregon Inc.
- Colorado Choice Health Plans (SLVHMO)
- Harvard Pilgrim Health Care
- Health Net Federal Services
- Johns Hopkins HealthCare LLC
- MMM Healthcare Inc.
- Neighborhood Health Plan
- Network Health (Massachusetts)
- Network Health Plan (Wisconsin)
- Peoples Health Network
- Primary Provider Management Company Inc.
- Rocky Mountain Health Plans
- Santa Clara Family Health Plan
- Sharp Health Plan
- Sterling Life Insurance Co.
- Texas Childrens Health Plan
- WINhealth
You are at the Registration User Information screen.

Complete all fields that are marked as required. These fields are indicated by a red asterisk.

The Password Reminder question may not contain any part of your password. Also, note that the password is case sensitive.

The Security Question and Security Answer will be used if you call the Help Desk to have your password reset.

When all fields are completed click Next to proceed to the Office Search screen.
Print Security Agreements

Please print a security agreement for each user that was created.

<table>
<thead>
<tr>
<th>Name</th>
<th>User ID</th>
<th>User Type</th>
<th>Security Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, John</td>
<td>JohnSmith</td>
<td>Provider Contact</td>
<td>Print Security Agreement</td>
</tr>
</tbody>
</table>

You are at the Print Security Agreements screen.

You must print a Security Agreement for each user that was registered by clicking on the link Print Security Agreement beside each user. Clicking on this link will open the security agreement in a new Adobe Acrobat or Adobe Reader window.

Note: If you have a Pop-up Blocker enabled you might need to turn it off to print the User Agreement(s). If you do not have Adobe Acrobat or Adobe Reader installed for your browser you can obtain it for free here.

Print all of the pages for each agreement. Note that the Important User Information page contains the User ID for each user as well as their temporary password. If your User Agreement indicates that it must be returned to your healthplan then your Connect account will not be activated until the signed User Agreement(s) have been received.

Once you have printed all the User Agreements click on Next.
Eligibility

- To conduct an eligibility search for patients, click *Eligibility* in Office Management in the left navigation menu.
Eligibility

• In eligibility, you have the option to search for patients via:
  ▫ Last Name
  ▫ Member ID
  ▫ SSN
  ▫ PCP
  ▫ Additional Search Filters: As of Date, Birth Date, Gender, Age
Eligibility

- Pick the patient’s search category and click *Search* for the results page.
  - *Ex: Searching by Patient Last Name ‘Anderson’*
Eligibility

- The *Search Results* lists all of the patients with that last name, with their *Sex*, *Effective Dates*, *Birth Date*, *Member ID* and *PCP*.

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Effective Dates</th>
<th>Birth Date</th>
<th>Member ID</th>
<th>Primary Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson</td>
<td>F</td>
<td>1 Jan 2000-</td>
<td>15</td>
<td>20J</td>
<td>Jeff</td>
</tr>
<tr>
<td>Anderson</td>
<td>M</td>
<td>1 Jan 2000-</td>
<td>7</td>
<td>20J</td>
<td>Jeff</td>
</tr>
<tr>
<td>Anderson</td>
<td>M</td>
<td>1 Jan 2000-</td>
<td>6</td>
<td>20J</td>
<td>John</td>
</tr>
</tbody>
</table>

- To view the patient’s Eligibility detail, click the *hyperlinked* Patient’s Name.
Eligibility - Detail

- **Eligibility Detail** displays **Patient Information** and **Benefit Information** pertaining to the specified patient.

- **Benefit Plan Information** can be found at the bottom of the screen.

<table>
<thead>
<tr>
<th>BENEFIT PLAN INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier</td>
</tr>
<tr>
<td>Product</td>
</tr>
<tr>
<td>Network</td>
</tr>
<tr>
<td>Group</td>
</tr>
<tr>
<td>Relationship</td>
</tr>
<tr>
<td>Enrollment Origination Date</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**

No COB information is available.

---

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>COPAY</th>
<th>CONGRESS</th>
<th>ELIGIBLE INDIVIDUAL</th>
<th>ELIGIBLE FAMILY</th>
<th>DEDUCTIBLE INDIVIDUAL</th>
<th>DEDUCTIBLE FAMILY</th>
<th>BENEFIT LIMIT</th>
<th>DOLLAR LIMIT</th>
<th>OUT OF POCKET MAX INDIVIDUAL</th>
<th>OUT OF POCKET MAX FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Injection</td>
<td>$5.00</td>
<td>$5.00</td>
<td>$5.00</td>
<td>$5.00</td>
<td>$5.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Cardiac Catheter</td>
<td>$20.00</td>
<td>$20.00</td>
<td>$20.00</td>
<td>$20.00</td>
<td>$20.00</td>
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<td></td>
<td>$0.00</td>
<td>$0.00</td>
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</tr>
<tr>
<td>Emergency Room</td>
<td>$120.00</td>
<td>$120.00</td>
<td>$120.00</td>
<td>$120.00</td>
<td>$120.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Home Care</td>
<td>$8.00</td>
<td>$8.00</td>
<td>$8.00</td>
<td>$8.00</td>
<td>$8.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>$8.00</td>
<td>$8.00</td>
<td>$8.00</td>
<td>$8.00</td>
<td>$8.00</td>
<td></td>
<td></td>
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<tr>
<td>Hospital Rehabilitation</td>
<td>$8.00</td>
<td>$8.00</td>
<td>$8.00</td>
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<td>$8.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>$20.00</td>
<td>$20.00</td>
<td>$20.00</td>
<td>$20.00</td>
<td>$20.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$30.00</td>
<td>$30.00</td>
<td>$30.00</td>
<td>$30.00</td>
<td>$30.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Office Visit - Network</td>
<td>$10.00</td>
<td>$10.00</td>
<td>$10.00</td>
<td>$10.00</td>
<td>$10.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Office Visit - Out of Network</td>
<td>$30.00</td>
<td>$30.00</td>
<td>$30.00</td>
<td>$30.00</td>
<td>$30.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Pharmacy - Tier 1</td>
<td>$10.00</td>
<td>$10.00</td>
<td>$10.00</td>
<td>$10.00</td>
<td>$10.00</td>
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<tr>
<td>Pharmacy - Tier 2</td>
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<td>$25.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Pharmacy - Tier 3</td>
<td>$45.00</td>
<td>$45.00</td>
<td>$45.00</td>
<td>$45.00</td>
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<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>$30.00</td>
<td>$30.00</td>
<td>$30.00</td>
<td>$30.00</td>
<td>$30.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>
Eligibility - Detail

- From the Eligibility Search Results, click Select to add that patient to the current patient list.
- Patient demographic information is also displayed.

![Eligibility Search Results]

![Currently Selected Record: AHP – Patient Information]
Claims

- The Claims link in Office Management helps providers do a general *Claim Status Search*, *Remittance Advice Search*, as well as *Add a Claim*. 
Claims

- After clicking on the claims link, the screen will default to *Claim Status Search*.

- The search options are:
  - Claim Number
  - Date of Service
  - Patient Name, Member ID, SSN, or Account Number
  - Provider
  - Bill Type
  - Status
Claims – Status Search

- Ex: Searching for a claim with Patient Last Name (Anderson).
- Click Search to continue.
Claims – Status Search Results

- The search results also provides *Date of Service (DOS)*, *Provider*, *Patient Responsibility* and *Payment Date*.

- To view the detail of a specific claim, click on the hyperlinked *Claim Number*.
Claims – Detail

- In Claim Status Detail, you can print the claim summary by clicking Print.
# Remittance Advice

**Patient Management**

- Current Patient: (None)
- Search Patients

**Office Management**

- Eligibility
  - Claims
    - Referrals/Auths
    - Provider Directory
    - Formulary
    - Code Lookup
    - Reports

**Administration**

- User Preferences
- System Admin
- Data Load Monitor

**References**

- Medical Links
- Search Help Files

### Remittance Advice Search Results

<table>
<thead>
<tr>
<th>Check Number</th>
<th>Check Date</th>
<th>Payment</th>
<th>Payor</th>
<th>Vendor Name</th>
<th>Vendor Address</th>
<th>Tax ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0002656861</td>
<td>5 Dec 2007</td>
<td>$3,123.92</td>
<td>PNHP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0002657296</td>
<td>5 Dec 2007</td>
<td>$12,225.79</td>
<td>PNHP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0002659126</td>
<td>12 Dec 2007</td>
<td>$5,230.15</td>
<td>PNHP</td>
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<tr>
<td>0002659329</td>
<td>12 Dec 2007</td>
<td>$2,571.95</td>
<td>PNHP</td>
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<tr>
<td>0002659750</td>
<td>12 Dec 2007</td>
<td>$6,560.69</td>
<td>PNHP</td>
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</tbody>
</table>
Remittance Additional Detail

Remittance Advice Detail For Check Number 0002656861 | Total Claims Paid: 20

<table>
<thead>
<tr>
<th>Check Date</th>
<th>Total Paid</th>
<th>Payor</th>
<th>Vendor Name</th>
<th>Vendor Address</th>
<th>Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Dec 2007</td>
<td>$3,123.92</td>
<td>PNHP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pages: (1) 2 3 4 Results: 20

Claim Number 071116E00035

<table>
<thead>
<tr>
<th>Provider</th>
<th>Patient</th>
<th>Patient Account Number</th>
<th>Member ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0013597871</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOS</th>
<th>Procedure</th>
<th>Modifier</th>
<th>POS</th>
<th>Units</th>
<th>Billed</th>
<th>Allowed</th>
<th>Withhold</th>
<th>Patient Responsibility</th>
<th>Disallowed</th>
<th>Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Nov 2007</td>
<td>43239</td>
<td>51</td>
<td>22</td>
<td>1</td>
<td>$850.00</td>
<td>$0.00</td>
<td>Patient Responsibility</td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>12 Nov 2007</td>
<td>45385</td>
<td></td>
<td>22</td>
<td>1</td>
<td>$1,320.00</td>
<td>$0.00</td>
<td>Patient Responsibility</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>12 Nov 2007</td>
<td>43239</td>
<td></td>
<td>22</td>
<td>1</td>
<td>$850.00</td>
<td>$0.00</td>
<td>Patient Responsibility</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

Totals $3,020.00

DOP: High - PAY: CODE REVIEW ADDED SERVICE
HL - PAY: CODE REVIEW REPLACED SERVICE
Electronic Funds Transfer (EFT)
Electronically Funds Transfer

Blue Cross and Blue Shields of North Carolina (BCBSNC) Financial Services offers electronic transfer of funds (“EFT”) for claims payments from BCBSNC to a contracted healthcare provider’s bank account.

EFT funds are accessible by providers sooner than remittances received through a traditional process of paper checks deposited by the provider.

Health care providers must submit:

- (1) a copy of a voided check or an account verification letter on bank letterhead.
- (2) an Electronic Funds Transfer Authorization form found on http://www.bcbsnc.com/asset/providers/public/pdfs/EFTrequest-form.pdf can be mailed or faxed to:

  BCBSNC Financial Services            Fax Number 919 765 7063
  Attention: Electronic Fund Transfer
  PO Box 2291
  Durham, NC 27702-2291
EFT - Benefits to the Provider

+ Cost reduction/elimination associated with paper checks being sent to lockboxes
+ Increases and improves cash flow management
+ Eliminates the risk of payments being lost in the mail
+ Eliminates the process of physically going to the bank to deposit claims payments made by BCBCNC - Go Green!
Signing up for EFT is easy!

- Access Blue e to complete the enrollment form or visit us online at: www.bcbsnc.com/providers.
  - The form is available for download from the “Network Participation” page, as well as the “Forms and Documentation” page.
- There is no cost for the service.
The chart highlights what is available for providers to receive electronically vs. paper.

- Providers can streamline their manual workflow processes by implementing these e-commerce options; enrollment forms are available on Blue e or via the Forms & Documentation page on the Provider Portal.

<table>
<thead>
<tr>
<th>Lines of Business</th>
<th>Electronic Funds Transfer (EFT)</th>
<th>Electronic Explanation of Payments (EOP)</th>
<th>Paper Explanation of Payment (EOP)</th>
<th>HIPAA 835 Remittance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial / State Health Plan</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>ASO</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>Federal Employees Program (FEP)</td>
<td>![ ] coming in 2013</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>Blue Medicare HMO</td>
<td>![ ]</td>
<td>![ ] *</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>Blue Medicare PPO</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
</tbody>
</table>

*Blue Medicare EOPs can be obtained via HealthTrio, as well as Blue e.
Break (10 minutes)
Two-year filing limit for corrected claims

+ BCBSNC will be implementing a new two year (24 month) time limitation for the submission of corrected claims and adjustments beginning January 1, 2013 to align with the North Carolina Prompt Pay law. This does not replace BCBSNC’s current 180 day filing requirement for the submission of new claims.

+ Medicare Advantage plans, the Federal Employee Program (FEP), and the State Health Plan (SHP) have different timely filing requirements.

Updates Regarding the FEP Migration to the Power MHS System

+ Effective May 16, 2013, we transitioned the claims processing system for the Federal Employee Program (FEP) from our Legacy system to our Power MHS system. Making the move to the newer 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 future Explanation of Payment (EOP) will have 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).

+ Participating providers enrolled for electronic funds transfer (EFT) will no longer have to wait for their manual checks to arrive in the mail – BCBSNC will electronically transfer funds directly into your account. This convenient feature will be coming soon.
In November, BCBSNC updated the CMS 1500 and UB04 claims entry screens:

- Fields pre-populated with the NPI number based on the user ID
  - Users can select a different NPI if linked to more than one BCBSNC provider number
- New data required on the access page and add page
- Optional data includes taxonomy code
- Expanded fields for reporting diagnosis codes
CMS 1500 changes

+ Date format changed to 6 digits for all dates except date of birth
+ Field 21 expanded to accommodate up to 12 diagnosis codes
  - Diagnosis pointer expanded to 4 with drop down box to indicate the appropriate diagnosis
+ Field 25 – Federal tax ID is now required
+ Field 26 – Patient Account number is required
+ Field 27 – Medicare Assignment is required for Medicare product claims
+ Field 33 – Billing provider information can now be edited by the user
UB04 changes

+ Date format changed to 6 digits with the exception of date of birth
+ Patient Control Number required
+ Tax ID number required
+ Admission Type required
+ Discharge status required
+ Form locator 66 – version indicator
  - This will default to ICD-9
+ Form locator 67 A – X expanded to accommodate 24 other diagnosis codes
New Functionality via Blue e –

Patient Care Summary (PCS)

A member level report* available through Blue e that includes:

+ Gaps in Evidence Based Care
  ▪ Chronic and Preventive, including months overdue

+ Prescription history
  ▪ Date of fill, prescriber, medication, dose, generic available, and information on meds ordered but not picked up
    – Summary page lists 10 most recent unique Rx
    – Detail page(s) list all Rx in last 12 months, including refills

+ Medical Care history
  ▪ Date of visit, provider, specialty, place of service and ICD codes
    – Summary page lists 10 most recent claims, with certain claims types omitted
    – Detail page(s) list all claims over last 36 months, and detail on associated diagnosis and procedure codes

+ Provider Alerts
  ▪ Generic alternatives available, and members we are trying to reach for Case Mgmt. services

* all information based on BCBSNC medical and pharmacy claims data
Demographics
Basic information such as Name, DOB, Age, etc.

Potential Gaps in Evidence Based Care
Gaps identified as past due per BCBSNC’s Claims data and evidence based guidelines

Prescriptions
On the first page of the report, you’ll see the patient’s 10 most recent unique prescriptions. Subsequent pages will display a complete 12 months Rx history, including refills and Rx that were never filled.

Most Recent Medical Care
The first page of the report will show the 10 most recent medical claims. Subsequent pages contain all of the patient’s medical claims and procedure codes from the past 36 months.

Provider Alerts
Actionable Alerts
Accessing the Patient Care Summary*

+ Requires a special “PCS” Blue e user role, which can be assigned by the Blue e administrator.

+ Select either the Health Eligibility or Patient Care Summary link. Both of these links will direct you to the same pages within the system.

*The PCS report is available for members of all commercial Lines of Business and members of the State Health Plan.
What do you need to do to get access to the PCS for use in your office?

- Talk to your practice’s Blue e administrator.
- Go to Blue e Help, “Patient Care Summary Reports” for Job Aide, FAQs and additional resources.
- For questions about how to access the report in Blue e, email the eSolutions HelpDesk at Bluee.helpdesk@bcbsnc.com or call 888-333-8594.
If you find that a patient’s Care Gap information is not correct or up-to-date, you can complete the **Patient Care Summary – Care Gap Change Request Form** and fax to 919-287-8886.

This form is available for download on the Blue e home page under the Related Links section.
Effective October 14, 2012, BCBSNC made changes to our claims processing system, which will automate claim filing requirements for ancillary providers and some providers may see changes in where their claims are processed.

The claim filing guidelines for ancillary providers are:

- Services performed by an Independent Clinical Laboratory (Lab) should be filed to the Blue Plan in which State the specimen was drawn.
- Durable/Home Medical Equipment and Supplies (DME) should be filed to the Blue Plan in which state the equipment was shipped to, or the location of the store if purchased at a retail location.
- Specialty Pharmacy claims should be filed to the Blue Plan based on the location of the Ordering Physician.

Effective October 1, 2012, ICD-9 codes should be assigned to the highest level of specificity using the fourth and fifth digits where applicable.

- After October 1, 2014, when ICD-10 has been fully implemented, ICD-10 codes should be submitted in alignment with the compliance date and assigned to the highest level of specificity applying up to the seventh digit where applicable, and providing the highest degree of accuracy and completeness.

BCBSNC system edits are in place to enforce and assist in a consistent claim review process.

For complete details, please review the communication notice found on the Important News page of the Provider Portal - [http://www.bcbsnc.com/content/providers/news-and-information/news/EnforcementofCorrectCodingGuidelines.htm](http://www.bcbsnc.com/content/providers/news-and-information/news/EnforcementofCorrectCodingGuidelines.htm)
Ancillary Service Referrals

+ Reminder to all participating network providers of your contractual agreement that when the need arises for a patient to receive other professional services - such as a referral for reference laboratory services, specialty pharmacy services or durable medical equipment (DME) rental/purchase - you will refer our members to other participating network providers.

+ If you are currently using the services and referring members to a non-participating provider, please refer the BCBSNC member to a participating provider.
  - For a list of specialty pharmacies and participating DME providers, please utilize the Find a Doctor tool on the www.bcbsnc.com Web site.
  - Please note, for participating network laboratories, you will need to contact the BCBSNC Customer Service phone number listed on the back of the members ID card.
**Medicare Pricing Policy Reminder**

- When new codes are published, or updates to existing codes occur, and an external pricing source exists for such codes, BCBSNC will implement such pricing by no later than April 1 of each year or within 30 days of source publication. Such updates and new pricing will apply for all dates of service on or after the source pricing effective date, but *only* for claims received after the date of BCBSNC’s implementation of the update/new pricing.

  - BCBSNC is not required to make retroactive pricing adjustments for claims received prior to BCBSNC’s implementation date.
Healthy Outcomes
On January 1, 2013, BCBSNC introduced Healthy Outcomes, a fully integrated health management solution for members.

Components of this new, encompassing health management program include:
- Healthy Outcomes Case Management
- Healthy Outcomes Condition Care
- Healthy Outcomes Wellness

As a result, some programs were discontinued:
- Blue Extras™—members can use Blue365™ = even more discounts
- Blue Points™—phased out effective 12/1/2012.
HealthyOutcomes

Support, centered around the member

Wellness
- Health Portal
- Health Assessment
- Online Education
- Online Tracking
- Wellness Incentive Tracking
- Health Screenings

Member Services
- Health Line Blue®
- Blue365® Discounts

Case Management
- Complex Care
- Catastrophic
- Intensive Care

Provider Integration
- Patient Care Summary
- Physician Reports
- Provider Engagement
- Care Reminders

Condition Care
- Asthma
- Diabetes
- CAD
- Heart Failure
- COPD

Maternity
- Maternity Management (for healthy and high-risk pregnancies)
- Postpartum Management
- Depression Screening
- 24/7 BabyLine®
Condition Care Programs

- Asthma
- CAD
- COPD
- Diabetes
- Heart Failure
- Pregnancy
- Musculoskeletal Pain Management (Optional)
  - Back pain (including upper and lower back and neck)
  - Rheumatoid arthritis
  - Migraines and tension headaches
  - Fibromyalgia
  - Tendonitis/Bursitis
  - Elbow and rotator cuff disorders
  - Carpal tunnel syndrome
  - Osteoarthritis
  - Frozen shoulder
  - Regional musculoskeletal disorders
- Depression (optional)
Condition Care Delivery Model

**Nurse Coach**
- Comprehensive clinical assessment
- Individualized care plans
- Care gap closure
- Participant education & empowerment through goal setting
- Compliance & adherence monitoring
- Risk re-stratification after every interaction

**Participant**
- Tele-monitoring when appropriate
- Lab & medication monitoring
- Education & goal setting
- Care gaps notification
- Health Portal
- In English and Spanish

**Provider**
- Timely, actionable provider reporting
- Pre-visit reports
- Alert reports
- Care gap reports
Condition Care Coaching

- Primary Nurse model
- Integrated with the BCBSNC Case Managers
- Support plan of treatment
- Behavior change methodologies
- Average nurse clinical experience- 20 years
- Low turnover rate
## Biometric Monitoring Programs & Process

<table>
<thead>
<tr>
<th>Program</th>
<th>Device Image</th>
<th>Device</th>
<th>Data Reported</th>
<th>Report Frequency</th>
<th>Review Frequency</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td><img src="example.png" alt="Image" /></td>
<td>DayLink Monitor</td>
<td>Symptoms</td>
<td>2x Day</td>
<td>Daily</td>
<td>Outbound call to participant for data out of parameters; actionable reports to Physicians</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Electronic Scale</td>
<td>Weight</td>
<td>2x Day</td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td><img src="example.png" alt="Image" /></td>
<td>DayLink Monitor</td>
<td>Symptoms</td>
<td>1x Day</td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td><img src="example.png" alt="Image" /></td>
<td>DayLink Monitor</td>
<td>Symptoms</td>
<td>1x Week</td>
<td>Every 2 Weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Glucometer</td>
<td>Blood glucose levels</td>
<td>1x Week</td>
<td>Every 2 Weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood Pressure Monitor</td>
<td>Blood pressure</td>
<td>Daily</td>
<td>Every 2 Weeks</td>
<td></td>
</tr>
</tbody>
</table>

Diabetes

- **DayLink Monitor**: Symptoms reported daily.
- **Glucometer**: Blood glucose levels reported weekly, reviewed every 2 weeks.
- **Blood Pressure Monitor**: Blood pressure reported daily, reviewed every 2 weeks.
Communication with the Provider through Physician Reports

- **Pre-Visit Report**
  - Faxed to physician 1 to 2 days prior to scheduled appointment
  - Provides between visit summary of relevant clinical data

- **Alert Report**
  - Faxed to physician when urgent member problem needs to be reported to physician*
  - 95% physician response

- **Care Gap Report**
  - Faxed or mailed to physicians on a quarterly basis
  - Built to support the plan of care

*Nurse determines an alert needs to be issued, fax sent and verified by phone, nurse instructs patient to call MD, nurse follows-up with the patient the next day to make sure they contacted the MD and re-contacts the physician if no contact.*
Health Line Blue℠ – 24/7 Nurse Line

- Single view of the member’s record for all care managers
- Train registered nurses
- Immediate triage
- Timely intervention
- Telephonic, secure messaging, and chat functionality
- In-network provider referrals
2013 Benefit Changes
The Affordable Care Act (ACA) requires the following changes to Women’s Preventative Care benefits upon a group’s effective date/renewal date on or after 8/1/2012:

- Human Papillomavirus (HPV) Testing for women >29 every 3 years
- Counseling on sexually transmitted infections (STIs) for sexually active women
- Annual HIV screening and counseling for sexually active women
- At least one wellness preventative care visit annually for adult women
- Breastfeeding support for pregnant/post-partum women
- Contraceptive methods and counseling
- Gestational Diabetes screening for pregnant women
- Annual screening/counseling for interpersonal/domestic violence for women

For complete details on the ACA changes and Preventative Care Services, please review the handout available on the Provider Portal at http://www.bcbsnc.com/assets/campaigns/public/preventive/pdf/hcr_preventive_services_grp.pdf
2013 Benefit Changes
Blue Medicare HMO\textsuperscript{SM} and Blue Medicare PPO\textsuperscript{SM}

Blue Medicare HMO:

✓ Formulary changes to the drugs covered and restrictions that apply to coverage for certain drugs.

Blue Medicare PPO:

✓ Co-pay changes
  - Primary care office visit (in-network)
  - Ambulatory surgery center visit
  - Outpatient hospital facility visit
  - Tier 1 (preferred generic) drugs

✓ Medicare-covered diabetic supplies and self-management training covered at 100%.

✓ Formulary changes to the drugs covered and restrictions that apply to coverage for certain drugs.
Pharmacy Benefit Changes

Blue Medicare HMO and Blue Medicare PPO

As of January 1, 2013 Blue Medicare HMO and Blue Medicare PPO members will transition to a new pharmacy benefits manager (PBM) - Prime Therapeutics®.

All pharmacy prior authorizations and patient medication history currently on file with Medco (our current PBM) will automatically be transferred to Prime Therapeutics (except controlled substances).

- Prime will contact physicians with Blue Medicare HMO and Blue Medicare PPO members who have controlled substance prescriptions in order to have the prescription replaced.
- Providers should watch for replacement of fax forms for PrimeMail as they will be available via the Provider Portal at www.bcbsnc.com in the near future.
Blue Medicare HMO and Blue Medicare PPO networks have been expanded into 7 additional North Carolina counties effective 1/1/2013.

The 7 counties added:
- Anson, Jones, Madison, McDowell, Mitchell, Pamlico, and Vance counties.
Federal Employee Program (FEP)
Hospice care
- The per admission copayments under for inpatient hospice care at a preferred hospice facility have been eliminated.
- The inpatient hospice stay day limit has been increased to 30 days per admission.
- Under Standard Option, the copayment for continuous home hospice care by a Preferred provider has increased from $200 to $250 per episode.

Urgent care center services
- Under Standard Option, $40 copayment only for all services provided by a Preferred urgent care center.
- Under Basic Option, $50 copayment only. The 30% coinsurance applied for drugs and supplies has been eliminated.
Hearing Aid Coverage
Federal Employee Program (FEP)

+ Hearing aids and related services
  - Benefits for bone-anchored hearing aids for adults and children have increased from $2,500 to $5,000 per calendar year. The benefit per ear has been eliminated.
    - Benefits for adult hearing aids and related services are available for up to $2,500 every three calendar years.
    - For children’s hearing aids and related services, benefits are available for up to $2,500 per calendar year.
Copayment changes for outpatient care:

- Copayment for outpatient physical therapy, occupational therapy, speech therapy and other rehabilitative services performed by a preferred hospital has decreased to $25 per day.
- Copayment for outpatient cardiac, cognitive and pulmonary rehabilitation has decreased to $25 per day when using a Preferred hospital.
- The copayment for other types of outpatient services billed by a Preferred facility, such as outpatient surgical care, radiation therapy and chemotherapy and renal dialysis has increased to $100 per facility per day for care.

Benefits for diagnostic tests related to an accidental injury performed in a setting other than an emergency room or urgent care center will be subject to a $25 or $75 per day copayment depending on the type of test performed.
Providers may also access and read the complete list of benefit changes in Section 2 of the 2013 Service Benefit Plan brochure available at http://www.fepblue.org/downloads/2013-service-benefit-plan-brochure_100512.pdf.

It is important to always obtain the most current member identification card and to verify eligibility and benefits via Blue e.
Blue Value
Blue Select
New Products for 2013

Blue Value

- Lower-cost plan with smaller network available to both individuals and groups.
- Point-of-service network.

Blue Select

- Tiered-benefit plan available only to employer groups.
Please note that ID card samples and the benefits noted on the ID card samples are for illustration and example purposes only. Actual benefits and amounts will vary based on the type of plan chosen by the employer group or the individual member.
Blue Value and Blue Select

Pharmacy Benefits

+ Formulary changes
  - Basic, closed formulary

+ Pharmacy network changes
  - Slightly smaller, yet statewide

+ Five-tier Rx benefit structure
  - MAC A pricing applies
Blue Value
The Target Audience: *Blue Value*

- Will appeal to price-sensitive individuals and small groups
- Opportunity to build / maintain patient relationships in advance of individual market reform
- Low utilization of insurance and/or health care services
- Located in these initial target markets
  - Wilmington, the Triangle and Winston-Salem
Provider Directory Search: Blue Value

Find a Doctor or Facility

Some office visits may be provided by a hospital-owned or operated practice and may be subject to your deductible and coinsurance. Some UNC Hospital independent clinics may only charge a copayment for routine or primary care services. Contact your health care provider prior to receiving services to find out how much you can expect to pay.

Choose a Plan
- Blue Advantage (Individual plan)
- Blue Assurance (Individual CMM plan)
- Blue Care (Group HMO Plan)
- Blue Options (Group PPO plan)
- Blue Options State Plan (North Carolina SmartChoice PPO Plan)
- Blue Options HRA (Group PPO plan)
- Blue Options HSA (Group PPO plan)
- Blue Options Individual PPO plan

- Blue Select (Group PPO plan)
- Blue Value (Group & Individual POS plan)
Benefit Differences: Blue Value

- No gatekeeper
- Smaller provider network
- Benefits—refer within Blue Value network for most member saving
- Pharmacy
The Member’s Role: How Blue Value Works

- Members locate Blue Value providers using the “Find a Doctor” search tool via Member Services at bcbsnc.com
  - Using an out-of-network provider results in higher out-of-pocket expenses for the member
  - Out-of-network claims will be paid to the member, who is responsible for paying the provider
  - If the member does not ensure that pre-authorization for out-of-network services is obtained, the claim will be denied
  - Members who need services not available in their network can apply for an exception for the service to be covered at the in-network level
The Target Audience: *Blue Select*

- Will appeal to medium and large groups
- Empowers members to take a greater role in managing their health care
- Controls health care costs while maintaining broad access
The Network: 
*Blue Select*

- Same PPO network, but with tiers
  - Tier 1 = Richer Benefits
  - Tier 2 = Higher Out-of-Pocket Expenses for Members

- Hospitals and specialists in five categories are rated by quality, cost and accessibility metrics as either Tier 1 or Tier 2

- All other specialists will be Tier 1 initially

- All specialty and critical-access hospitals are Tier 1
Provider Directory Search:
Blue Select

Blue Select (Group PPO plan)
Benefit Differences:

*Blue Select*

+ **Tiered Benefits**
  - Two in-network benefit tiers
  - Copayment and coinsurance are tiered benefits
  - Deductible is not a tiered benefit
  - Only one in-network deductible or coinsurance maximum—not separate ones for each tier

+ All medical policy coverage is the same as for our other products

+ Pharmacy network and prescription drug coverage changes
The Member’s Role: How Blue Select Works

- Members determine a provider’s tier status using “Find a Doctor” search tool via Member Services at bcbsnc.com
  - Search defaults to member’s correct product or network
  - Search results display provider tier status

- Member selects in-network Blue Select provider
  - Member must check provider tier status with BCBSNC
  - Accessibility based on network status (not tier status)

- Member pays higher copayment/coinsurance when using Tier 2 providers

- Out-of-network benefits are also available
Provider Education
Pharmacy Resources
Most members who take specialty medications have complex chronic conditions and specialty medications can, at times, be received through a member’s MEDICAL and/or PHARMACY benefits.

In order to assist these members and meet their unique medical needs, BCBSNC created a new specialty pharmacy network for the medical and pharmacy benefit for commercial business.

Further details regarding the new BCBSNC Specialty Pharmacy Network can be accessed on the BCBSNC Provider Portal external site at: http://www.bcbsnc.com/content/providers/injectable-drugs/available.htm.
TransactRx

+ TransactRx is a Part-D Vaccine Manager that makes available through it’s online access, real-time claims processing for in-office administered Medicare Part-D vaccines.

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

+ Signing up is easy … https://enroll.mytransactrx.com

Transact Rx Customer Support Center
1-866-522-EDVM (3386)
Electronic prescribing (ePrescribing) is an efficient, economical and secure way of using health care technology 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.

- ePrescribers electronically and securely incorporate patient medical information with health plan formulary, patient eligibility and medication history at the point of care.

- The result is a safe and efficient process with more accurate medication orders being electronically sent to the patient’s pharmacy of choice.
Inter-Plan Programs (IPP)
Verifying Eligibility

+ The member’s Blue Plan maintains member eligibility information.
+ There are two ways providers may verify member eligibility and coverage information:

1-800-676-BLUE (2583)
Member ID Cards: BlueCard Program

+ Blue Card member ID cards have a suitcase logo.
+ The suitcase logo may appear with or without “PPO” in the logo.
+ The suitcase logo identifies the reimbursement level to the provider, **not** member benefits.
Suitcase with PPO

- The member is enrolled in a PPO or EPO product (the back of the card may identify benefit limitations for EPO members).
- The provider is reimbursed at the Local Plan’s PPO reimbursement level.

Suitcase without PPO

- The member is enrolled in a Traditional, HMO, or POS product.
- The provider will be paid at the Local Plan’s Traditional (for Traditional and HMO products) or POS reimbursement level.
Providers have access to medical policies and general prior review requirements from the member’s Home Plan:

- Provider will enter alpha prefix in a designated area(s) on the BCBSNC Provider Portal website at: [http://www.bcbsnc.com/content/providers/medpol_ppa_router.htm](http://www.bcbsnc.com/content/providers/medpol_ppa_router.htm).
- Provider will then be routed to the Home Plan’s medical policy and/or prior review requirements.
- Once medical policy and prior review requirements are viewed, provider will then be reconnected back to the BCBSNC website.
IPP Radiology Management Services

+ BlueCard members from out-of-state Blues Plans are not included in the BCBSNC radiology management program administered through AIM Specialty Health.
  
  - However, it’s important to always verify a member’s eligibility and prior authorization requirements, as a member may be enrolled in a benefit coverage plan that includes authorization prior to receiving certain radiological services.

+ To verify:
  
  – Call the number on the member’s identification card
  – Call 1-800-676-Blue
  – Blue e
Medicare Crossover is an automatic claims submission process for Medicare claims to the Blue secondary payer.

- It reduces or eliminates the need for the provider’s office or billing service to submit an additional claim to the secondary carrier.

For members with Medicare primary and BCBS secondary coverage:

- Submit claims to your Medicare intermediary or carrier.
- On the Medicare claim, be sure to enter the correct Blue Plan name as the secondary payer. This may not be BCBSNC and you can verify the plan name by checking the member's ID card.
- Report the member's BCBS identification number including the alpha prefix.
Understanding the Four Pronged Approach

A four-pronged approach is used to prevent issues, resolve inquiries and increase overall satisfaction.

- Contact BCBSNC for all claim inquiries
- Take advantage of educational opportunities
- Utilize electronic services via Blue e
- Submit claims to BCBSNC Plan
+ BCBSNC serves as the “one-stop shopping” for all BlueCard and other Inter-Plan claim inquiries from participating and non-participating providers in North Carolina.

+ Providers should contact the member’s Plan only for eligibility, care management inquiries, and for status on Medicare primary claims that have crossed over directly to the Home Plan.
  - BlueCard Eligibility Line (800) 676-BLUE
  - Electronically through Blue e or HIPAA 270/271
Medical Policy
The medical policies* on the BCBSNC Medical Policy Web page reflect medical criteria used/developed by Blue Cross and Blue Shield of North Carolina. These medical policies do not guarantee benefits under BCBSNC member contracts.

BCBSNC only displays the most current version of a medical policy. When updated policies become effective, prior versions are removed from this Web site.

*The medical policy details outlined in the following slides are for BCBSNC local lines of business and the State Health Plan; please see the next section for IPP BlueCard and Blue Medicare HMO / Blue Medicare PPO.
The medical policy consists of medical guidelines, including diagnostic imaging management policies, payment guidelines and evidence based guidelines.

<table>
<thead>
<tr>
<th>Medical Guidelines</th>
<th>Payment Guidelines</th>
<th>Evidence Based Guidelines</th>
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<tbody>
<tr>
<td>Alphabetical Index</td>
<td>Alphabetical Index</td>
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<tr>
<td>Categorical Index</td>
<td>Categorical Index</td>
<td>Categorical Index</td>
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<tr>
<td>Diagnostic Imaging Management Policies</td>
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BCBSNC providers have the ability to view medical policies that apply specifically to your out-of-area Blue Plan patients. Additionally, health care providers will have the ability to access general precertification/preauthorization requirements, along with contact information to initiate precertification/preauthorization requests.

http://www.bcbsnc.com/content/providers/medpol_ppa_router.htm
Medical Policy Information for Out-of-Area Members

To obtain the medical policy precertification/preauthorization information for out-of-state members:

- Select the type of information requested
- Enter the patient's three letter alpha prefix that precedes the ID number and click "GO"
- You will then be routed to the Home Plan's medical policy and/or prior review requirements
- Once medical policy and prior review requirements are viewed, you will then be reconnected back to the BCBSNC website
As a Medicare Advantage (MA) plan, BCBSNC is required by Centers for Medicare & Medicaid Services (CMS) to provide, at a minimum, the same medical benefits to our members as original Medicare. As a MA plan, we also cannot be less restrictive that original Medicare, however, we are allowed to clarify or more fully explain coverage in our policies. If original Medicare does not have an NCD or LCD applicable to the service under review, the MA plan can develop a guideline to define the plan's coverage. Each individual's unique, clinical circumstances may be considered in light of current CMS guidelines and scientific literature.

http://www.bcbsnc.com/content/providers/blue-medicare-providers/medical-policies/index.htm
These guidelines detail when certain medical services are considered medically necessary and are based on Original Medicare National Coverage Determinations (NCD's) & Local Coverage Determinations (LCD's) when available. The guidelines are reviewed and updated in response to changing CMS guidelines for medical coverage or change in scientific literature if applicable.
Medical Policy Updates

+ BCBSNC updates the medical policies twice a month. A complete list of medical policies that have been updated are available for review on the Medical Policy Updates Web page.

+ Each listing includes the name of the policy and a general explanation of the update. You can view the individual policy by locating it within the medical policy search.
Provider Appeals
Level I Post Service Appeal Timeline

- Level I Post Service Appeals are available to physicians, physician groups, physician organizations and facilities.

- Providers have **90** calendar days from the claim adjudication date to submit a Level I Appeal.

- The Level I Provider Appeal form is for use only when requesting a review for a post service coding denial, medical necessity denial, or an inpatient administrative denial due to no authorization.

  - If your inquiry does not meet the criteria for an appeal, providers will need to complete a Provider Inquiry Form and submit to the following address:

    BCBSNC – PO Box 2291 – Durham NC 27702
The Level I Provider Appeal form should **not** be used for FEP. Please refer to the Provider Blue Book for explanation on how to appeal for FEP claims.

To ensure that your appeal is handled efficiently, please fax the appeal form to the appropriate department fax number listed on the form.
Appeals Process

+ Providers may not appeal any issues that are considered member benefit or contractual issues.
  – Deductible/coinsurance issues
  – Benefit limitations
  – Benefit exclusions
  – Membership issues

+ If at any time a member and/or their authorized representative requests an appeal during the review of a provider submitted appeal, the member’s appeal takes precedence.
  – At this time, the provider appeal will be closed.
The Blue Medicare appeals process is in-line with the commercial lines of business appeals process.

The Blue Medicare Level I Provider Appeal form is available online at [http://www.bcbsnc.com/content/providers/blue-medicare-providers/post_service_provider_appeals.htm](http://www.bcbsnc.com/content/providers/blue-medicare-providers/post_service_provider_appeals.htm).
IPP Post Service Appeal

+ When the member’s Home Plan denies a claim for benefit reasons and the provider disputes the denial, the provider is able to submit an appeal on the member’s behalf.
  – Please send an appeal on letterhead advising the claim is being appealed on the member's behalf to P.O. Box 2291. The appeal will NOT be sent to the member’s Home Plan if the appeal request is not on letterhead.

+ A Level I Appeal form is to be used only when a provider disagrees with pricing and/or a bundling issue.
The appeal process is voluntary; a third party (such as a provider billing agency) can now act on the provider's behalf in the appeal process.

Level I Provider Appeal reviews will be completed by BCBSNC within 30 calendar days from the receipt date of all information.

To check the status of an appeal, please contact Customer Service directly as they have access to an enhanced level of information and will be able to provide a status update.
ICD-10 Readiness
ICD-10: Federal Mandate

+ ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2014. Otherwise, claims and other transactions will be rejected and will need to be resubmitted.

+ It is important to start now to prepare for the changeover to ICD-10 codes. Delays may impact your reimbursements.
ICD-10-CM Structure

+ Approximately 69,000 unique codes

+ 3-7 Characters in length
  - First character must be alpha
    – Implies 26 “families”
  - Next character must be numeric
    – Implies 99 “subfamilies”
  - Rest can be either alpha or numeric

+ Designed for clinical detail
  - Explicit use of laterality (right, left, bilateral)
  - Explicit use of trimesters in pregnancy
  - Explicit use of visit information – initial, subsequent, sequela
  - Explicit use of fracture information – routine healing, delayed healing, nonunion, malunion
ICD-10-PCS Structure

- Approximately 72,000 unique codes

- 7 alpha-numeric characters
  - First character defines clinical section
  - Remaining characters assigned to specific characteristics within a section

- Expanded space designed to add:
  - Explicit laterality
  - Detailed body parts descriptions
  - Methodology and approach details by procedure
  - Allow specificity as procedures change with technology
ICD-10 will change everything.

**Physicians**
- **Documentation:** The need for specificity dramatically increases by requiring laterality, stages of healing, weeks in pregnancy, episodes of care, and much more.
- **Code Training:** Codes increase from 17,000 to 140,000. Physicians must be trained.

**Nurses**
- **Forms:** Every order must be revised or recreated.
- **Documentation:** Must use increased specificity.
- **Prior Authorizations:** Policies may change, requiring training and updates.

**Clinical Area**
- **Patient Coverage:** Health plan policies, payment limitations, and new ABN forms are likely.
- **Superbills:** Revisions required and paper superbills may be impossible.
- **ABNs:** Health plans will revise all policies linked to LCDs or NCDs, etc., ABN forms must be reformatted and patients will require education.

**Lab**
- **Documentation:** Must use increased specificity.
- **Reporting:** Health plans will have new requirements for the ordering and reporting of services.

**Billing**
- **Policies and Procedures:** All payer reimbursement policies may be revised.
- **Training:** Billing department must be trained on new policies and procedures and the ICD-10-CM code set.

**Coding**
- **Code Set:** Codes will increase from 17,000 to 140,000. As a result, code books and styles will completely change.
- **Clinical Knowledge:** More detailed knowledge of anatomy and medical terminology will be required with increased specificity and more codes.
- **Concurrent Use:** Coders may need to use ICD-9-CM and ICD-10-CM concurrently for a period of time until all claims are resolved.

**Managers**
- **New Policies and Procedures:** Any policy or procedure associated with a diagnosis code, disease management, tracking, or PQRI must be revised.
- **Vendor and Payer Contracts:** All contracts must be evaluated and updated.
- **Budgets:** Changes to software, training, new contracts, new paperwork will have to be paid for.
- **Training Plan:** Everyone in the practice will need training on the changes.

**Front Desk**
- **HIPAA:** Privacy policies must be revised and patients will need to sign the new forms.
- **Systems:** Updates to systems are likely required and may impact patient encounters.
“Make Proper Documentation a Priority”

+ Identify most frequently used ICD-9-CM diagnosis codes.
+ Pull charts – start with most frequently used codes.
+ Determine what ICD-10 should be used.
+ Check that your documentation is specific enough to assign a code in ICD-10-CM.
+ Educate, as necessary, to bring physicians up to speed.

According to AAPC, 40-45 percent of all provider notes will need some type of supplementing to assign an ICD-10-CM code.
ICD-10: Industry resources

+ BCBSNC
  ▪ [http://www.bcbsnc.com/content/providers/legislative/icd10.htm](http://www.bcbsnc.com/content/providers/legislative/icd10.htm)

+ CMS

+ AHA

+ AHIMA
  ▪ [http://www.ahima.org/icd10/](http://www.ahima.org/icd10/)

+ AAPC

+ NCHICA
  ▪ [http://www.nchica.org/HIPAAResources/icd10.htm](http://www.nchica.org/HIPAAResources/icd10.htm)
Provider Tools
Customer Service Phone Numbers

+ **Provider Blue Line** – **1.800.214.4844**
  – Dedicated provider line for health care providers participating in BCBSNC commercial lines of business.

+ **Blue Medicare HMO/PPO** – **1.888.296.9790**
  – Dedicated provider line for health care providers participating in BCBSNC Blue Medicare HMO and Blue Medicare PPO benefit plans.

+ **Network Management Specialists** – **1.800.777.1643**

+ **eSolutions Customer Service** – **1.888.333.8594**

+ **IPP Blue Card (verify eligibility)** – **1.800.676.BLUE (2583)**

+ **IPP Blue Card (claims assistance)** – **1.800.487.5522**.

+ **State Health Plan** – **1.800.422.4658**

+ **Federal Employee Program (FEP)** – **1.800.222.4739**
Provider Services Associates (PSA)

Your PSA’s are able to assist with:

- Providing you information on how to obtain your fee schedule (if you are unable to retrieve via Blue e)
- Making any necessary demographic changes – notice address, billing address and etc.
- Add/Remove providers from your practice
- Questions

P: (800) 777-1643 8am-4pm
F: (919) 765-4349
NMSpecialist@bcbsnc.com
Patient Education Materials

+ BCBSNC has identified and developed patient assessment and patient education materials to help jumpstart preventive health conversations.

**Healthy Lifestyle Programs**
- Adult Obesity Assessment and Treatment
- Childhood Obesity Assessment and Treatment
- Tobacco Cessation
- Stress Management

**Preventive Screening Topics**
- Breast Cancer Screening
- Chlamydia Screening
- Colorectal Cancer Screening
- Depression Screening

+ These *complimentary* tools can help you assess your patients on important preventive health issues – to request, please complete the online order form at [http://www.bcbsnc.com/content/providers/toolkit/order-toolkit.htm](http://www.bcbsnc.com/content/providers/toolkit/order-toolkit.htm).
The SilverSneakers® Fitness Program is available at no additional cost and offers Blue Medicare HMO and Blue Medicare PPO member’s access to gyms and other programs to help them get healthy and stay healthy.

To learn more about SilverSneakers visit www.silversneakers.com.
Online resources - bcbsnc.com/providers/

+ Online provider manuals
+ Medical policies
+ Important news
+ Prior review pages
+ Newsletters
+ Much more!
Thank you!

This presentation was last updated on February 8, 2013. BCBSNC tries to keep information up to date; however, it may not always be possible. For questions regarding any of the content contained in this learning module, please contact Network Management at 1.800.777.1643.