Welcome to BCBSNC…

2014 Regional Provider Workshops
Today’s Agenda

- Introductions
- Provider Web Portal
- Electronic Solutions
- Operational Updates
- Benefit Changes
- Blue Value and Blue Select
- Provider Education
- ICD-10 Readiness
- Provider Tools
- Conclusion
Provider Web Portal
Provider Portal

Have you visited us on the Web lately?

Provider Portal highlights include:

- **Provider news** including Blue Medicare
- 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](http://www.bcbsnc.com/providers)
BCBSNC Launches Patient Care Summary for Physicians

Blue Cross and Blue Shield of North Carolina (BCBSNC) recently rolled out the Patient Care Summary (PCS) to a pilot group of physicians. The PCS is a comprehensive tool to help providers proactively manage their patients’ overall health. The PCS provides summary of health-related services care experience. The PCS is designed to support the provider’s decision-making process when assessing the need for additional services.

With the PCS, doctors can quickly:
- Identify gaps in care for individual patients compared to evidence-based and nationally recognized guidelines.
- See a comprehensive listing of the patient’s medication.
- Review recent medical care received including date of visit, doctor, facility name, specialty, diagnosis, procedure codes, and place of service.

PCS information is refreshed monthly, and it will include information about any care or medication for which a claim was paid. This information is available on the provider’s website. The PCS is currently available for Medicare Supplement or Federal Employee Program members.

The initial pilot was launched in May 2021 at all Blue Cross Blue Shield of North Carolina (BCBSNC) practices, a group of 10 pilot practices.

The PCS is available to physicians who care for BCBSNC members and BCBSNC Blue E+U members. The provider needs to request to participate in the pilot.

For articles specific to your area of interest, look for the appropriate title.
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

Powered by ExactTarget.
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
Signing 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
  ▪ HealthTrio
    – 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

Enrolling in HIPAA Transactions

- BCBSNC Commercial (Blue Options, State Health Plan, FEP and IPP)
  http://www.bcbsnc.com/content/providers/edi/hipaainfo/index.htm

+ Companion guides for all HIPAA transactions are located on our web site at 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
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
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.
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
Under the Affordable Care Act, members who receive a premium subsidy from the government and are delinquent in paying their portion of their premium are given a three-month grace period.

This federally mandated grace period applies as long as the individual has previously paid at least one month’s premium within the benefit year.

The grace period starts with the first day of the month after the Paid Thru Date through the last day of the third month.

Claims with dates of service within the first month of the grace period will be processed as normal. However, insurers may pend claims for services rendered during the second and third months of the grace period.
Blue e Health Eligibility Grace Period Display

+ **Blue e Health Eligibility** Inquiries will identify ACA Exchange members, and provide an “Alert” notice if they are within the grace period for the date of service requested.

+ The notice advises of the exact paid-through dates, as well as the start and end dates of the member’s grace period.

+ An “Additional Information” flyover message advises that received payments may not display in *Blue e* for up to four days, and that BCBSNC customer service professionals cannot discuss member payment with providers.
Blue e Health Eligibility Grace Period Display

**Member Information**

- **Member Number:** YPIW1234567801
- **Name:** JOHN DOE
- **Address:** 123 ELM STREET
  POPLAR BRANCH, NC 27965
- **Sex:** Male
- **Date of Birth:** 01/01/1970
- **Rel. to Subscriber:** SUBSCRIBER

**Policy Information**

- **Product:** BLUE ADVANTAGE COPAY
- **Group Number:** IADVTC
- **Group Name:** BLUE ADVANTAGE ON APTC
- **Insurance Type:** BLUE ADVANTAGE COPAY-Underwritten Group
- **Group Benefit Period:** 01/01/2014 - 12/31/9999

**Alert:** Member is in 1st month of the HIX (Health Insurance Exchange) grace period due to non-payment of premium. Claims with dates of service within the 1st month of the grace period will be processed as normal. The member's paid through date is 04/30/2014. The grace period started on 05/01/2014 and ends 07/31/2014. [ADDITIONAL INFORMATION]

**Member Liability Summary**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>In-Network</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Max per Benefit Period</td>
<td>Year-to-Date Remaining</td>
</tr>
<tr>
<td>CoInsurance</td>
<td>n/a</td>
<td>Out-of-Pocket includes Copay, Deductible, and Coinsurance. See Help pages</td>
</tr>
<tr>
<td>Deductible</td>
<td>$500.00</td>
<td>$19.98</td>
</tr>
</tbody>
</table>

[ADDITIONAL INFORMATION fly-over states: "Recently made payments may take 48 to 72 hours to appear in Blue e. Be advised BCBSNC service staff can discuss billing information with the member only."]
HIPAA X12 271 Health Eligibility Response

- HIPAA X12 271 Health Eligibility Responses contain two discrete values in the first EB segment, depending on whether the member is in the first month of his/her grace period or the 2-3 months of the grace period.

- A value of EB01 = 1 (Active coverage) is returned for members within the first month.

- For members in the 2-3 month of the grace period, the EB01 = 5 (Active – pending investigation).
HIPAA X12 271 Health Eligibility Response

- DTP*343*D8*20140430~
- **EB*5**30*PR*BLUE ADVANTAGE COPAY-Underwritten Group~
- DTP*193*D8*20140501~
- DTP*194*D8*20140729~
- MSG*HIX GRACE PERIOD~

Grace Period Indicator
HealthTrio
Web portal connecting providers to BCBSNC Medicare Advantage members’ eligibility and claims information
- Applicable for Medicare PPO℠ and Blue Medicare HMO℠

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
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
User Information

If you are an existing user of the Connect system **click here to login**.

- **First Name** *
- **Middle Initial**
- **Last Name** *
- **Title** *
- **E-Mail** *
- **Confirm E-Mail** *
- **Office Phone** *
- **Office Fax** *
- **Clinician**
  - [ ] Check this box if you are a clinician
- **User Name** *
- **Password** *
- **Confirm Password** *
- **Password Reminder** *
- **Security Question** *
- **Security Answer** *
- **Local Admin**
  - [ ] As the primary registrant, you are automatically a local admin

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.
# HealthTrio Registration

**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 Search](image)
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.

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.
Eligibility - Detail

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

| Claim Number | Status | Patient | Patient Account No | DOS         | Provider | Billed | Paid | Deduction | Balance | Out | Expense | Deductible | Patient Responsibility | Claimable Amount |
|--------------|--------|---------|--------------------|-------------|----------|--------|------|-----------|---------|-----|---------|------------|----------------------|------------------|------------------|
| 012345678901 | Drafted| Doe John| VT12345678         | 01 Apr 2021 | John Doe | $45.00 | $30.00| $0.00     | $10.00 | $0.00|$0.00    | $0.00        | $0.00            | $0.00            |
| 023456789012 | Drafted| Doe John| VT23456789         | 02 Apr 2021 | John Doe | $50.00 | $35.00| $0.00     | $10.00 | $0.00|$0.00    | $0.00        | $0.00            | $0.00            |
| 034567890123 | Drafted| Doe John| VT34567890         | 03 Apr 2021 | John Doe | $55.00 | $40.00| $0.00     | $10.00 | $0.00|$0.00    | $0.00        | $0.00            | $0.00            |
| 045678901234 | Drafted| Doe John| VT45678901         | 04 Apr 2021 | John Doe | $60.00 | $45.00| $0.00     | $10.00 | $0.00|$0.00    | $0.00        | $0.00            | $0.00            |

*Source: HealthTrio LLC*
Claims – Detail

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

```
<table>
<thead>
<tr>
<th>Claim Status Detail for</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CLAIM LEVEL INFORMATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider: NICE Smith MD</td>
<td></td>
<td>Practice: ACME Medical Center</td>
</tr>
<tr>
<td>Patient: JOHN DOE</td>
<td></td>
<td>Patient Account No: VT123383</td>
</tr>
<tr>
<td>Diagnosis: V70.0: ROUTINE GEN MED EX@HEALTH CARE FACIL</td>
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<td></td>
</tr>
<tr>
<td>SERVICE LINE INFORMATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Line</td>
<td>Status</td>
<td>Check/EFT Number</td>
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</tbody>
</table>
```

**Additional Information**

**Payor Remarks**

- **Remark: 001** 45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

- Indicates non-standard HIPAA data element
Remittance Advice

### 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>
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<td></td>
<td></td>
</tr>
<tr>
<td>0002659126</td>
<td>12 Dec 2007</td>
<td>$5,230.15</td>
<td>PNHP</td>
<td></td>
<td></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>
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</table>
Remittance Additional Detail

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

<table>
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<tr>
<th>Check Date</th>
<th>Total Paid</th>
<th>Payor</th>
<th>Vendor Name</th>
<th>Vendor Address</th>
<th>Tax</th>
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</thead>
<tbody>
<tr>
<td>5 Dec 2007</td>
<td>$3,123.92</td>
<td>PNHP</td>
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</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>
<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>
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<td>12 Nov 2007</td>
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</tbody>
</table>

EOP: H6 - PAY: CODE REVIEW ADDED SERVICE
HL - PAY: CODE REVIEW REPLACED SERVICE
Electronic Funds Transfer (EFT)
EFT - Payment Made Fast and Easy

+ Direct Deposit of Claims Payments to your bank account

+ **All** product lines are now available for direct deposit:
  - Federal Employees Program (FEP)
  - Commercial / State Health Plan
  - ASO
  - Medicare Supplement
  - Blue Medicare HMO
  - Blue Medicare PPO

+ Safer than paper checks which can get lost, stolen, or damaged

+ EFT funds are accessible by providers sooner than manual paper checks arriving in the mail.

+ Enroll online via *Blue e* or fax in form from www.bcbsnc.com
Signing up for EFT is easy!

- Access Blue e to complete the enrollment form or visit us online at: [www.bcbsnc.com/providers](http://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.

What’s the secret to improved cash flow and faster reimbursements?

**BCBSNC Electronic Funds Transfer**

Electronic Funds Transfer (EFT) is your easiest and most convenient choice for receiving reimbursement from Blue Cross and Blue Shield of North Carolina.

**Benefits:**
- Faster reimbursement of payments transferred electronically post to your account before normal checks, making your funds accessible sooner.
- Predictable transfer of funds—EFT makes cash management easier. Bank deposit holds can improve your overall cash flow management.
- Less paperwork and lower administrative costs—no more time spent opening envelopes and endorsing checks, preparing deposits and making trips to the bank.
- Reduced opportunity for error or theft—Deposits are made directly into a designated bank account of your choosing.
- Possible elimination or reduction of lockbox service fees.
- EFT savings reimbursement helps preserve our environmental resources.

**Security:**
- EFT offers security by using the same secure network used by federal banks and government institutions.
- EFT is a faster, more efficient way to pay, transferring electronically and passing through fewer hands than a check.
- EFT eliminates the risk of lost or stolen checks.

**Next Steps:**
- Access Blue e® to complete the enrollment form. If you do not have access to Blue e®, please complete the attached form.
- Concerned about disclosing bank information? Ask your financial institution about ACH blocks.
- Concerned about associating EFT to ERA? Ask your financial institution about viewing ACH addenda records.

Sign-up is easy and there’s no cost for the service!

Simply complete the following form, attach a voided check and return to BCBSNC.
Latest Provider News
Changes to Blue e CMS1500 Claims Transaction

+ As of March 29, 2014, the Blue e® CMS-1500 claims transaction will reflect changes in response to the National Uniform Claims Committee’s (NUCC) changes to the CMS-1500 paper claim form.

+ There were new edits when entering claims on Blue e
  - new qualifiers, taxonomy code at the rendering provider level, and changes such as the corrected claim indicator being moved.

+ Visit the “Resources” section on Blue e for more details regarding the actual form changes, and take action as needed to inform and educate your billing and office staff.
Cover My Meds
Convenience of completing and submitting pharmacy-related prior review requests directly to BCBSNC via CoverMyMeds’ free and secure online portal

Many of our network physicians and pharmacies already use CoverMyMeds

Access all of BCBSNC’s pharmacy-related prior review forms, check member eligibility, as well as submit medical details directly to BCBSNC when necessary for us to complete review of medications requiring prior review
Ensure Your Patients Get the Medications You Prescribe

+ Have your provider NPI handy, as it is now required on all BCBSNC pharmacy-related prior review forms, regardless of whether you use CoverMyMeds or continue faxing requests to BCBSNC.

+ Many pharmacies in North Carolina are already connected to CoverMyMeds.

+ There’s no requirement to use CoverMyMeds*, but we think you’ll welcome the efficiencies and real-time responses gained with new electronic solution.
Take A Tour to See How CoverMyMeds Works: https://www.covermymeds.com/epa/bcbsnc/
Red, White and Blue NC
BCBSNC cares about our members that have served or are currently serving in the military.

- Helping **providers** understand the unique set of needs military servicemen, women and their families require will allow our members to receive the best care possible.

- **Providers** will receive free, online BCBSNC developed training, free third party training (CEUs offered upon completion) and useful links to third party information [www.bcbsnc.com/redwhiteandbluencprovider](http://www.bcbsnc.com/redwhiteandbluencprovider)

- **Members** will also benefit from having useful links at their fingertips in one consolidated location [www.bcbsnc.com/redwhiteandbluencmember](http://www.bcbsnc.com/redwhiteandbluencmember)
BCBSNC provider training includes:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Veterans Affairs (VA) 101</th>
<th>Assisting Veterans in Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking a Military History</td>
<td>Traumatic Brain Injury</td>
<td></td>
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</tr>
<tr>
<td>Military Family Issues</td>
<td>Issues Affecting Women in the Military</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Do’s and Don’ts”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BCBSNC rewards community-based primary care practices to complete the BCBSNC trainings through the company’s long-standing Blue Quality Physician Program.

Did You Know?
- One in 10 adults living in North Carolina has served in the United States military.
- North Carolina is the third largest state in per capita population of service men, women and their families.
Other training and resources

<table>
<thead>
<tr>
<th>Citizen Soldier Training</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating the invisible wounds of war</td>
<td>Community Provider Toolkit</td>
</tr>
<tr>
<td>A Primary Care Approach</td>
<td>VA/DoD Clinical Resource Guides</td>
</tr>
<tr>
<td>Recognizing the Signs of mTBI During Routine Eye Examinations</td>
<td>Military History Resources</td>
</tr>
</tbody>
</table>

[www.bcbsnc.com/redwhiteandbluencprovider](http://www.bcbsnc.com/redwhiteandbluencprovider)
BCBSNC’s New Technology Platform
This April, BCBSNC began migrating to a new technology platform in an effort to better support industry changes, such as Affordable Care Act requirements and to replace our existing claims processing systems.

This new platform will provide a technology suite for many of our customer interactions, including the sales, enrollment, customer service, claims processing, product administration, and provider experiences.

- It is designed to increase the efficiency in membership operations and also streamline the shopping, quoting and enrollment of prospective employer groups.
Member Migration

+ The transition to the new technology platform will be gradual. The first customer segment enrolled on the new technology suite will be new, Small employer groups consisting of 1 to 50 members.
  - Utilizing a controlled, multi-year, phased-migration approach, we expect to have all of our commercial membership migrated onto the new technology platform by the end of 2016.

+ As the system migration is internal to BCBSNC, there will be no impact to how you submit claims. **There will be no changes to the fee schedule under your provider contract with BCBSNC as a result of the system change.**
Member ID Number

- You will notice the following changes to BCBSNC ID numbers for those members who have migrated to the new system:
  - The new member ID number (only for those who have migrated to the new system) will still consist of 14 positions; a three-position alpha prefix followed by numeric values.
  - The members who are being set up on the new system can be recognized by the new alpha prefixes on their BCBSNC ID cards: YPS, YPQ or YPU.
  - There will no longer be a “W” in the ID number for those members who have migrated to the new system.
  - Members who have not yet migrated to the new system will continue to have a “W” in their BCBSNC ID numbers.
Claims Enhancement

+ A claim that is submitted with multiple providers will be split internally for processing within BCBS. There is a potential that if one part has not fully processed the other approved portion will be paid in one check cycle and the subsequent claim/portion will be paid in the next payment cycle after it finalizes.

+ This means there is a potential of a single claim sent with different providers at the line level, paying in separate payment cycle. This will allow providers to receive payment more promptly by allowing the approved claim portion to pay without being held until the other portion (claim) is approved.

+ Please keep in mind that this will only occur for claims submitted for BCBSNC membership that has migrated to the new technology platform.

+ There will be separate checks for Power and Facets members.
Viewing members

- For the members on the new technology platform, there will be no changes when looking at these members online, providers will follow the same processes for members enrolled on our existing platforms.

- If you have any questions, please contact the Provider Blue Line at 1-800-214-4844.
Healthy Outcomes
BCBSNC offers 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
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)

Over 150,000 members identified for one of these conditions (~10% of those eligible for these programs)
Comprehensive clinical assessment
Individualized care plans
Care gap closure
Participant education & empowerment through goal setting
Compliance & adherence monitoring
Risk re-stratification after every interaction

Tele-monitoring via DayLink® Monitor, when appropriate
Education & goal setting
Care gaps notification
Health Portal
In English and Spanish

Provider reporting:
Pre-visit reports
Alert reports
Care gap reports

Over 5,000 members are currently engaged in nurse coaching
## Home 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="image" alt="Heart Failure" /></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="image" alt="COPD" /></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="image" alt="Diabetes" /></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>CAD</td>
<td><img src="image" alt="CAD" /></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>Blood Pressure Monitor</td>
<td>Blood pressure</td>
<td>Daily</td>
<td>Every 2 Weeks</td>
<td></td>
</tr>
</tbody>
</table>

Over 1,100 members are currently using one of these devices
Home Monitoring Process

Condition Monitoring Program
For Inclusion in Patient Chart / Physician Review

[Providername]
[Provideraddress1]
[Provideraddress2]
[Providercity], [Providerstate] [Providerzip]

Dear [Providername],

As you know, [Participant Name] participates in the [Program Name] (condition program) Program. This program is supported by the evidence-based guidelines. Please refer to the Alere web site, www.AlereCares.com/ClinicalGuidelines to view these evidence-based guidelines. Our services are not intended to replace regular communication between you and your patient.

A benefit of the program for your patient is our in-home DayLink® telemonitoring device, which is offered at no additional cost. The DayLink® telemonitoring device records daily responses to symptoms questions including blood sugar and BP readings (if applicable). All recorded information is sent to Alere and reviewed by a registered nurse. If a symptom change is reported, a registered nurse will call your patient to verify the change and further assess their condition. Once the change is verified, the nurse will notify you of this fact via fax.

If you are in support of [Participant name] using our DayLink® telemonitoring service, we would appreciate you completing and returning the attached prescription form. Your support of the program goes a long way in encouraging your patients’ follow-through with your care plan.

If you have any questions or comments, feel free to contact us toll-free at [phone number]. We always welcome any suggestions regarding this service.

Please complete and return this prescription form

[Participant name]
[Participantaddress1]
[Participantstate] [Participantzip]

DOB: [mm/dd/yyyy]

_____ Add Alere DayLink® Monitor to be used in accordance with the instructions from Alere nurses as part of the State of Delaware [Program name] Program

_____ Alere DayLink® Monitor service is not needed at this time

Physician signature __________________________ Date __________________

Physician Address: [Provideraddress1]
[Provideraddress2]
[Providerstate] [Providerzip]
[Provider Phone]

Fax to return prescription: 610-239-0582

Participant privacy is important to us. All of our employees are trained regarding the appropriate way to handle our participants’ private health information.
Communication with the MD 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

Status

- Provides information relevant to managing patient’s health

Alert

- Faxed to physician when urgent member problem needs to be reported to physician*

*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.
Communication with the MD through Physician Reports

- Mailed to physician when the member engages with a nurse coach

- Faxed to physician when a member problem related to medications needs to be reported to the physician
### Physician Report Volumes:

<table>
<thead>
<tr>
<th>Report</th>
<th>Asthma</th>
<th>COPD</th>
<th>CAD</th>
<th>Diabetes</th>
<th>Heart Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Visit</td>
<td>23</td>
<td>69</td>
<td>92</td>
<td>414</td>
<td>2</td>
</tr>
<tr>
<td>Status</td>
<td>4</td>
<td>284</td>
<td>455</td>
<td>627</td>
<td>1,234</td>
</tr>
<tr>
<td>Alert</td>
<td>1</td>
<td>39</td>
<td>58</td>
<td>40</td>
<td>61</td>
</tr>
<tr>
<td>Medication</td>
<td>37</td>
<td>97</td>
<td>101</td>
<td>562</td>
<td>76</td>
</tr>
<tr>
<td>Enrollment Letters</td>
<td>373</td>
<td>496</td>
<td>620</td>
<td>3,700</td>
<td>249</td>
</tr>
<tr>
<td>Audience</td>
<td>Method</td>
<td>Frequency</td>
<td>Notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------</td>
<td>-----------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>Letter/Portal</td>
<td>Monthly</td>
<td>Top 3 care reminders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD’s</td>
<td>Letter/Fax</td>
<td>Quarterly</td>
<td>Individual patient and summary report are sent. Method of communication dependent on the # of pages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alere Nurses/BCBSNC Case Managers</td>
<td>Clinical System</td>
<td>Monthly</td>
<td>All care alerts are viewable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2015 Benefit Changes
State Health Plan - Autism

+ Beginning on January 1, 2015, SHP will provide benefits for the treatment of Autism Spectrum Disorder (ASD)

+ Benefit Design
  - Codes and Services to be included are under review
  - Benefit design ongoing

+ Provider Network
  - Under development
Blue Value
Blue Select
Value Based Products

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

BluValue

- Tiered-benefit plan available only to employer groups.

BluSelect
Blue Value:
✓ YPV (individual coverage)
✓ YPL (group coverage)

Blue Select:
✓ YPX

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
- Low utilization of insurance and/or health care services
- Located in these initial target markets
  - Wilmington, the Triangle and Winston-Salem
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.

Provider Finder

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 HSA (Individual PPO plan)
- Blue Select (Group PPO plan)
- Blue Value (Group & Individual POS plan)

Advanced Search
- Search by Specialty
- Search by Specialty Issue
- Search by Health Issue
- Search by Drug

Choose a Plan
- Blue Select (Group PPO plan)
- Blue Value (Group & Individual POS plan)

Provider or Office Name

Hospital or Facility Name

Providers or Practices

Site Info Print My List

Save time and money.

Know your ER alternatives.
Benefit Differences: *Blue Value*

- No gatekeeper
- Smaller provider network
- Benefits—refer within Blue Value network for most member savings
- 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
Blue Select
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*

- **Specialty Search**
  - Search by Specialty
  - Search by Health Issue

- **Location Search**
  - All Patient Types (Both Adult / F)
  - Within 25 miles of 28456
  - Street Address or City and State

- **Provider Search**
  - Blue Select (Group PPO plan)

- **Advanced Search Options**
  - Male
  - Female
  - Board Certified Only
  - Accepting New Patients
  - Non-hospital Based Clinics

- **Tier Option**
  - Tier 1
  - Tier 2
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
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)

Electronically through Blue e
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.
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.

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.
IPP Medical Policy and Prior Review Router

+ 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.
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
IPP and Medicare Crossover

- 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
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>
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<tr>
<th>Medical Guidelines</th>
<th>Payment Guidelines</th>
<th>Evidence Based Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alphabetical Index</strong></td>
<td><strong>Alphabetical Index</strong></td>
<td><strong>Alphabetical Index</strong></td>
</tr>
<tr>
<td><strong>Categorical Index</strong></td>
<td><strong>Categorical Index</strong></td>
<td><strong>Categorical Index</strong></td>
</tr>
<tr>
<td><strong>Diagnostic Imaging Management Policies</strong></td>
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</tbody>
</table>
+ 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
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.

Medical Policy Update for June 12, 2012
Medical Policy Update for May 29, 2012
Medical Policy Update for May 15, 2012
Medical Policy Update for May 1, 2012
Medical Policy Update for April 17, 2012
Medical Policy Update for March 30, 2012
Medical Policy Update for March 20, 2012
Medical Policy Update for March 6, 2012
Medical Policy Update for February 21, 2012

Medical Policy Update for February 7, 2012
Medical Policy Update for January 24, 2012
Medical Policy Update for January 10, 2012
Medical Policy Update for December 30, 2011
Medical Policy Update for December 20, 2011
Medical Policy Update for December 6, 2011
Medical Policy Update for November 22, 2011
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
Level 1 Provider Appeal Form Required as of September 1, 2014

+ BCBSNC discontinued all other options for our commercial business as of September 1, 2014, in lieu of the more efficient online form.
+ FAX NUMBERS:
+ Review of a medical necessity denial, including no preauthorization for an inpatient stay:
  ▪ Fax to BCBSNC at (919)287-8709
+ Review of coding or bundling denials:
  ▪ Fax to BCBSNC at (919)287-8708
+ Review of State Health Plan PPO authorization denials:
  ▪ Fax to BCBSNC at (919)765-2322
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.
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.
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.
Final Appeals Reminders

- A third party (such as a provider billing agency) can now act on the provider's behalf in the appeal process.

- Provider Appeal reviews are completed within 45 calendar days of the receipt of all information for commercial business and 30 days for Medicare Advantage.

- 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: Be Ready!
Deadline for ICD-10 allows health care industry ample time to prepare for change

**Deadline set for October 1, 2015**

The U.S. Department of Health and Human Services (HHS) issued a rule finalizing Oct. 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases. This deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on Oct. 1, 2015.

For more information on the rule, [view the press release](#).

**Keep Up to Date on ICD-10**

Visit the CMS [ICD-10 website](#) for the latest news and resources to help you prepare. Sign up for [CMS ICD-10 Industry Email Updates](#) and [follow us](#) on Twitter.
BCBSNC ICD-10 Updates

+ Updated FAQ’s on website (www.bcbsnc.com/icd10)
+ Update external website with relevant resources
  ▪ BCBSNC continues to monitor CMS and industry resources for updated materials and implementation guidelines.
+ ICD-10 – ongoing topic for discussion at NC Medical Group Manager meetings through 2015
+ Regional Provider Conferences (ICD-10 agenda topic)
  ▪ September 16, 2014 Greenville, NC
  ▪ September 18, 2014 Charlotte, NC
  ▪ September 23, 2014 Chapel Hill, NC
+ Provider Readiness Re-assessment
  ▪ Targeted for 1st Quarter 2015
ICD-10. Let’s cross the finish line

- BCBSNC message around ICD-10 readiness and compliance remains the same.
- BCBSNC will be ready for ICD-10 implementation on the CMS compliance date.
- BCBSNC encourages all covered entities to take advantage of the extra time from the delay to catch-up and continue moving forward with ICD-10 implementation.

Testing

- BCBSNC is currently piloting the end-to-end testing approach with a large health care system.
- BCBSNC will evaluate the results of the pilot and finalize its approach for end-to-end testing with other providers in the Fall of 2014.
eSolutions Testing

+ BCBSNC is not requiring testing for the ICD-10 codes. However, BCBSNC has RampManager set up to facilitate ICD-10 testing for those EDI trading partners who wish to test.

+ RampManager testing allows for HIPAA X12 syntax and structure only. It will not provide any end to end testing.

+ RampManager can be accessed through BCBSNC’s secure Blue e provider portal.

+ For questions regarding RampManager, please contact Guy Ferrari at (919) 765-7092 or Guy.Ferrari@BCBSNC.com.
ICD-10 Medical Policy Revisions

In preparation for the health care industry’s conversion to the 10th version of the International Classification of Diseases code set (ICD-10), Blue Cross and Blue Shield of North Carolina (BCBSNC) is in the process of reviewing our online medical policies to identify those that contain ICD-9 code information, and we’re making updates to the policies identified to also include ICD-10 diagnosis codes.

The medical policies listed below were updated to include ICD-10 diagnosis code information. We will continue reviewing our medical policies to make any necessary ICD-10 code updates and will add updated policies to the list below on an ongoing basis.

Providers who use practice management systems that contain ICD-9 code information are encouraged to review the list of medical policies below, and make any applicable ICD-10 code set updates within their management systems, including clinical and financial applications where codes are housed and accessed for reporting.

Updated ICD-10 Medical Policies:
- Capacitance Balloon
- Cardiovascular Disease Risk Tests
- Chemoradiation of the Hepatic Artery, Transcatheter Approach
- Cord Blood as a Source of Stem Cells
- Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in MS
- Dopamine Transporter Imaging with Single Photon Emission CT
- Gastro-Electrical Stimulation
- Gender Reassignment Surgery
- Hematoma Pallet Inflammation for HRT in Women
- Intensive Care Unit
- Laser Treatment for Pink Wine Stains
- Molecular Markers in Fine Needle Aspirates of the Thyroid
- Non-Pharmacological Treatment of Rosacea
- Occipital Nerve Stimulation
- Percutaneous and Internal Iliac Venoplasty
- Rehabilitation for the Treatment of Resistant Asthma
- Robotic Resection for Primary and Metastatic Tumors of Liver
- Sacral Nerve Neuromodulation/Stimulation for Pelvic Floor Dysfunction
- Systems Pathology for Shunting of Bile Ducts in Papillary Cystitis
- Vagus Nerve Stimulation
- Varicos Veins Treatment

Search for medical policies and guidelines and get policy updates that are not specific to changes for ICD-10.
CMS Releases ICD-10 Training and Preparation Webcast

The Centers for Medicare & Medicaid Services (CMS) has released a new webcast with information on ICD-10 training and preparation from the “Road to 10” tool. Accessible through the “Road to 10” link on the CMS website, the webcast discusses key elements to include in your training plan. This is the second webcast in the new “Road to 10” series. Four more webcasts will follow—all aimed at helping small physician practices get ready for ICD-10 by the October 1, 2015, compliance date.

Go to the CMS ICD-10 website to get started on the “Road to 10” today.
CMS Releases ICD-10 Clinical Documentation and Coding Webcast

The Centers for Medicare & Medicaid Services (CMS) has released a new webcast with information on clinical documentation and coding from the “Road to 10” tool, which was designed to help small physician practices transition to ICD-10. Accessible through the “Road to 10” link on the CMS website, the webcast discusses how transitioning to ICD-10 will impact documentation and coding in small physician practices. This is the third webcast in the new “Road to 10” series. Three more webcasts will follow—all aimed at helping providers get ready for ICD-10 by the October 1, 2015, compliance date.

Go to the CMS ICD-10 website to get started on the “Road to 10” today.
ICD-10 Testing Opportunities for Medicare FFS Providers

On July 31, HHS issued a rule (CMS-0043-F) finalizing October 1, 2015, as the new compliance date for health care providers and health plans to transition to ICD-10. ICD-10 represents a significant code set change that impacts the entire health care community.

CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS, as well as the Medicare Fee-For-Service (FFS) provider community, is ready:

- CMS internal testing of its claims processing systems
- CMS Beta testing tools available for download
- Acknowledgement testing
- End-to-end testing

For more information, see MLN Matters® Special Edition Article #SE1409, “Medicare FFS ICD-10 Testing Approach.”

Acknowledgement Testing

This past March, CMS conducted a successful ICD-10 acknowledgement testing week. Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, special acknowledgement testing weeks in November, March, and June of 2015 will give submitters access to real-time help desk support and allow CMS to analyze testing data. Registration is not required for these virtual events. Contact your Medicare Administrative Contractor (MAC) for more information about acknowledgment testing.

End-to-End Testing

CMS plans to offer providers and other Medicare submitters the opportunity to participate in end-to-end testing with MACs and the Common Electronic Data Interchange (CEDI) contractor in January, April, and July of 2015. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of three testing periods. The goals of this testing are to demonstrate that:

- Providers and submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims
- Accurate Remittance Advises are produced

Additional details about end-to-end testing will be available soon.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website for the latest news and resources to help you prepare.
Provider Tools
Online Provider Search Tools
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Online Provider Search 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.BLUER (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
Customer Service Professional (CSP)

+ Your CSP’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
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).
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 September 15, 2014. 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.