Welcome to BCBSNC…

2012 Total Access Provider Training

3rd Quarter
Today’s Agenda

+ Introductions
+ Provider Web Portal
+ Electronic Solutions
+ Latest News and Updates
+ Provider Education
+ ICD-10 Readiness
+ Provider Tools
+ Conclusion
+ One-on-One Resource Time
Provider Web Portal
The “All New” Provider Portal

Have you visited us on the Web lately?

New portal highlights include:

- **Email Registry** sign-up
- 24/7 virtual provider **e-learning center**
- Interactive provider **forms, documents**, and **manuals**
- Quick access to **BlueCard®, Blue Medicare®, and Dental Blue® information**
Important News –
Be in the know

Stay up-to-date by visiting us on the Web at:
www.bcbsnc.com/providers
Online tools
Available at any time, from anywhere

+ Important information that can make your job easier is available at the click of a button.

  – News and Information
  – Forms and Documentation
  – Email Registry
  – Medical Policies, Prior Review and Appeals
  – Blue Medicare
  – Education and Learning Center
  – eManuals
  – ICD-10 Readiness
  – And much more

Check it out and take a tour!
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.
Chart Your Path to Administrative Success on the Provider Portal

http://www.bcbsnc.com/providers

Start

Get resources and tools to help you prepare for ICD-10

Access to Medical Policy, Prior Review & Appeals

Education & Learning Center – videos, webinars and podcasts

IPP BlueCard - get resources for servicing out-of-area members

See information specifically for Blue Medicare providers

Managing Claims & Electronic Resources – discover how Blue e can help your practice & access CMS-1500 & UB-04 claims specific information

Find all of the Forms you need in one convenient place

BCBSNC Provider Portal

Get the latest news by signing up for the Email Registry

Check out current Provider News articles

Access to online reference eManuals
+ **Email Registry** - Stay informed with important announcements from BCBSNC of important policy and practice changes, regional news, online course offerings and much more.
+ **News & Information** - See current news and information that affects providers, as well as our online newsletters.
+ **eManuals** - Access the online reference eManuels - the guides include information on our products, services, claims billing, policies and much more.
+ **Forms & Documentation** - Find all of the forms you need in one convenient place, including appeals forms, enrollment applications and credentialing forms.
+ **Managing Claims & Electronic Resources** - Discover how Blue eSM can help you manage claims, eligibility and remittance inquiries. Also access claims specific information for CMS-1500 and UB-04 claim filers.
+ **Blue Medicare** - See information specifically for Blue Medicare HMOSM and Blue Medicare PPOSM providers.
+ **IPP BlueCard®** - Get resources for providers who service out-of-state Blue Cross/Blue Shield members.
+ **ICD-10** - Get resources and tools to help you prepare for ICD-10 implementation.
+ **Medical Policy, Prior Review and Appeals** - Search for a medical policy, see prior review requirements and learn about the appeals process.
+ **Education & Learning Center** - View videos, see webinars and listen to podcasts about the training topics important to you and your practice.
Electronic Solutions
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

https://providers.bcbsnc.com
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](http://www.bcbsnc.com/content/providers/index.htm)
  - HealthTrio

+ 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
Blue e Homepage

What's New
- Ancillary Service Referrals New!
- FEP Claims Processing Enhancements

Eligibility
- FEP Member Name Search
- Health Eligibility

Billing
- 837 Claim Error Listing
- Claim Status
- Clear Claim Connection (C3)
- Remittance Inquiry

Health Management
- Authorization Request
- Case Status
- Diagnostic Imaging Management

Administration
- BCBSNC Disclosures
- Fee Schedules

Related Links
- Find a Form
- Prior Plan Approval (PPA) List
- Out of state member Medical Policy/Pre-cert/auth
- ePrescribe for online prescriptions
- Medicare Advantage
To Verify Benefits – click Eligibility

- FEP Member Name Search
  Search for FEP member ID numbers.

- Health Eligibility
  Search for detailed eligibility information for BCBSNC, State Health Plan, Federal Employees Plan (FEP), or other BCBS members.
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**
- **Member Last Name**
- **Member First Name**
- **Member Date of Birth**
- **Date of Service**

Ex: YPP0000000000

Ex: MMDDCCYY
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 Max per Benefit Period</th>
<th>Single Year-to-Date Remaining</th>
<th>Family Max per Benefit Period</th>
<th>Family Year-to-Date Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoInsurance</td>
<td>n/a</td>
<td>$3000.00</td>
<td>$3000.00</td>
<td>$3000.00</td>
</tr>
<tr>
<td>Deductible</td>
<td>$3000.00</td>
<td>$2278.58</td>
<td>$3000.00</td>
<td>$2278.58</td>
</tr>
<tr>
<td>Out-Of-Pocket</td>
<td>$6000.00</td>
<td>$5278.58</td>
<td>$6000.00</td>
<td>$5278.58</td>
</tr>
</tbody>
</table>

#### Out-of-Network

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Single Max per Benefit Period</th>
<th>Single Year-to-Date Remaining</th>
<th>Family Max per Benefit Period</th>
<th>Family Year-to-Date Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoInsurance</td>
<td>n/a</td>
<td>$6000.00</td>
<td>$6000.00</td>
<td>$6000.00</td>
</tr>
<tr>
<td>Deductible</td>
<td>$6000.00</td>
<td>$6000.00</td>
<td>$6000.00</td>
<td>$6000.00</td>
</tr>
<tr>
<td>Out-Of-Pocket</td>
<td>$12000.00</td>
<td>$12000.00</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
Member Information

Benefits

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

<table>
<thead>
<tr>
<th>COVERAGE LIMIT - UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits Usage: VISITS: 30; 30 remaining for SERVICE YEAR</td>
</tr>
</tbody>
</table>
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: [Field]
Member Number: [Field]
Claim Number: [Field]

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

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

## BCBSNC Claims for Provider

Total # of Claims: 54

<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

To search for the status of a claim, select a Provider, enter a Member Number and a Date of Service. Then click the Search button.

*Required fields

**Provider Number**

**Member Number**

Ex: YPP000000000

**Date of Service**

Ex: MM/DD/YYYY

Search

For FEP or Out-of-State Member Claim Status

Please check the Search Results to view the results of searches conducted over the past 7 days.

View Search Results
### Claim Status Display

#### Claim Status Detail for: 808697808697

- **Member:** Victoria Blue-Shield
- **Member No.:** YPPW000000000
- **Product:** BLUE OPTIONS
- **Medical Record Number:** 936989369
- **Place of Service:** 22
- **Claim Reference Number:** 00123456789101

#### Claim Status: Finalized

**Timeline**

<table>
<thead>
<tr>
<th>Date of Service Start</th>
<th>Date of Service End</th>
<th>Received Date</th>
<th>Check Payment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/05/2009</td>
<td>01/05/2009</td>
<td>01/14/2009</td>
<td>01/20/2009</td>
</tr>
</tbody>
</table>

**Payment Information**

<table>
<thead>
<tr>
<th>Billed Charges</th>
<th>Contracted Charges</th>
<th>NCGS Interest Paid</th>
<th>Deductible Amount</th>
<th>Coinsurance Amount</th>
<th>Copay Amount</th>
<th>Amount Paid</th>
<th>Check Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>$853.00</td>
<td>$853.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$503.27</td>
<td>3826690</td>
</tr>
</tbody>
</table>
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.
<table>
<thead>
<tr>
<th>What's New</th>
<th>Eligibility</th>
<th>Health Management</th>
<th>Administration</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>837 Claim Error Listing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEP Members List</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ancillary Service Referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear Claim Connection (Eff.06/09/2012)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear Claim Connection (Eff.01/01/2012-06/08/2012)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear Claim Connection (C3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear Claim Connection (Eff.10/01/2011-12/31/2011)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remittance Inquiry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related Links**
- Find a Form
- Prior Plan Approval (PPA) List
- Out of state member
- Medical Policy/Pre-cert/auth
- ePrescribe for online prescriptions
- Medicare Advantage
Select the C3 edition based on the date the claim processed.
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></td>
<td>1.22</td>
<td>100</td>
</tr>
<tr>
<td>Allow</td>
<td>80061</td>
<td>06/27/2012</td>
<td>LIPID PANEL</td>
<td></td>
<td>0.00</td>
<td>100</td>
</tr>
<tr>
<td>Disallow</td>
<td>36415</td>
<td>06/27/2012</td>
<td>ROUTINE VENIPUNCTURE</td>
<td></td>
<td>0.00</td>
<td>0</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 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.

<table>
<thead>
<tr>
<th>* Required fields</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Provider Number:</td>
</tr>
<tr>
<td>* Choose a Network:</td>
</tr>
</tbody>
</table>

* Find:  
- Specific CPT or HCPCS Code:  
  - EX: 12345
- Range of CPT or HCPCS Codes (up to 100 codes):  
  - EX: 12345 to EX: 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.

![Fee Schedule for](Image)

**Fee Schedule for**

Please review the medical policy which could impact the amount paid for a specific procedure.

*IC = Individual Consideration

<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 HIDRO...</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, USINGIMAGING 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>
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</tr>
<tr>
<td>19499</td>
<td>UNLISTED PROCEDURE, BREAST</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

< New Search

*IC = Individual Consideration

(c) = Conversion Factor for anesthesia
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
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
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

- 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>20</td>
<td>Jeff</td>
</tr>
<tr>
<td>Anderson</td>
<td>M</td>
<td>1 Jan 2000-</td>
<td>7</td>
<td>20</td>
<td>Jeff</td>
</tr>
<tr>
<td>Anderson</td>
<td>M</td>
<td>1 Jan 2000-</td>
<td>6</td>
<td>20</td>
<td>Colby</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.
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*.
Claims – Detail

- In Claim Status Detail, you can print the claim summary by clicking Print.
## 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>
<td></td>
<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>
<td></td>
</tr>
<tr>
<td>0002659329</td>
<td>12 Dec 2007</td>
<td>$2,571.95</td>
<td>PNHP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0002659750</td>
<td>12 Dec 2007</td>
<td>$6,560.69</td>
<td>PNHP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Remittance Additional Detail
Electronic Funds Transfer (EFT)
Electronic 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](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](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.
Break (10 minutes)
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 Management services

* all information based on BCBSNC medical and pharmacy claims data
Accessing Patient Care Summary

+ The Patient Care Summary Report is accessible on the Home page of Blue e - [https://providers.bcbsnc.com](https://providers.bcbsnc.com).
  - 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 Patient Care Summary Report:
Provides the user with a snapshot of the member’s most recent care experience

**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
The Patient Care Summary Detail Report captures all claim activity for prescriptions in the last 12-months and medical care in the past 36-months. The *Detail Report* appears subsequent to the summary information.

If you find that a patient’s Care Gap information should be changed, locate the *Patient Care Summary – Care Gap Change Request Form* on the Blue e home page under the Related Links section.

For questions about Report content, incorrect patient information or navigating the report, please call the Provider Line$^{SM}$ at 1-800-214-4844.
Many large practices using Blue e already manage their own onsite Blue e users and eSolutions has now identified additional provider practices to become self-administered. This means your organization will have the ability to add/remove/update Blue e users without having to consult eSolutions support.

- As part of this effort, emails were sent to Blue e users in larger practices, asking for someone at the practice to accept the administrator role for Blue e.
- For smaller practices that have only one or two Blue e users, access has been given for you to administer your account by clicking on Entity Management on the Blue e Home page.

If you have questions regarding this change, please email us at Bluee.helpdesk@bcbsnc.com or call the eSolutions HelpDesk at 1-888-333-8594.
In conjunction with the recent expansion of electronic funds transfer (EFT) to our Medicare Advantage (MA) lines of business, we have implemented duplex printing (two-sided printing) of Explanation of Payments (EOPs) for our Medicare Advantage (MA) and Medicare Supplement products.

As a reminder, duplex printing applies to ALL Medicare Advantage and Medicare Supplement participating providers - regardless if you are or are not currently a BCBSNC EFT participant.
Beginning in October, BCBSNC will be offering real-time claim status connectivity for all trading partners that are CAQH CORE certified.

- Two new connectivity protocol will be available for both Health Eligibility (270/271) and Claim Status (276/277) transaction types. Real-time and batch file formats will also be available for these transactions.

This offering makes BCBSNC compliant with CAQH/CORE operating rules that support the Affordable Care Act. The Department of Health and Human Services (DHHS) has adopted these operating rules, and has mandated compliance by January 1, 2013.

For complete details, please review the communication notice found in Blue e - [http://www.bcbsnc.com/content/providers/news-and-information/news/RealTimeClaimStatus.htm](http://www.bcbsnc.com/content/providers/news-and-information/news/RealTimeClaimStatus.htm).
2012 Consumer Transparency Updates

- BCBSNC is committed to providing Blue members with the best-in-class tools they need to effectively partner with their doctors and make more informed health care choices. As part of that effort and along with other Blue Plans, patient reviews of North Carolina physicians posted on our website will now be available to Blue Plan members across the country on the Blue National Doctor & Hospital Finder.

- Also now available to members nationwide is a new program from the Blue Cross and Blue Shield Association, Blue Physician Recognition, via the Blue National Doctor & Hospital Finder. This program recognizes physicians who have demonstrated a commitment to delivering safe, evidence-based, and patient-centered care through participation in accepted national, regional, or local quality improvement or recognition programs and resources.
Correct Coding Guidelines

+ Effective October 1, 2012, ICD-9 codes should be assigned to the highest level of specificity using the fourth and fifth digits where applicable.
  - Once a final ruling has been made on the proposed ICD-10 implementation delay, 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
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.
Provider Education
Pharmacy Resources
Prime Therapeutics

As of April 1, 2012 BCBSNC’s commercial membership transitioned 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) have been automatically transferred to Prime Therapeutics (except controlled substances).

- Prime will contact physicians with BCBSNC commercial members who have controlled substance prescriptions in order to have the prescription replaced.

The change to Prime Therapeutics as our new PBM only applies to our commercial group and individual business (excludes Blue Medicare products and FEP). The State Health Plan will remain with Medco as their PBM.
Beginning August 9th changes have been made to the Self-Administered Drug list and will impact all commercial members who currently take these Self-Administered medications.

- Certain self-administered drugs are **ONLY** covered under the prescription drug benefit and are *excluded* from BCBSNC's medical benefit. While members have the freedom to self-administer these medications, they can still obtain these medications at the pharmacy and take them to their doctor's office, where they can receive training on how to self-administer them.

The [Self-Administered Drug list](https://www.bcbsnc.com/content/services/formulary/injectmed.htm) has been updated and has been attached for your review; this listing is also available for download from the Pharmacy page on the Provider Portal Web site at: [https://www.bcbsnc.com/content/services/formulary/injectmed.htm](https://www.bcbsnc.com/content/services/formulary/injectmed.htm).
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.
Prior Review & Quantity Limit Updates

Effective October 1, 2012

+ Prior review will be required and quantity limitations will apply for Fidaxomicin (Dificid™), Capsaicin 8% patch (Qutenza) and Oxycodone HCL extended-release (OxyContin) for ALL users.

+ Prior review will be required for Hereditary Angioedema therapy: Firazyr, Cinryze, Kalbitor, Berinert for ALL users and Repository corticotropin (H.P. Acthar Gel) for ALL users.

+ For complete details on the provider review changes effective, October 1, 2012, please access the Prior Plan Approval page on the Provider Portal at http://www.bcbsnc.com/content/providers/ppa/prescriptions.htm.

- Applies to all commercial members who have their pharmacy benefits with us. These changes will not apply to State Health Plan, Federal Employee Program, Medicare Part D members, or for any ASO employer groups that carve out their pharmacy benefits to another pharmacy benefits manager.
+ October 1st - prior approval required on the following drugs:

- Alpha Interferons
- Heredity Angioedema (HAE)
- Immune Globulins subcutaneous (SC Ig)
- Repository Corticotropin (H.P. Acthar Gel)

Initiate the prior coverage review process at:

medco.com/coverage

Or call:

1.800.753.2851

Complete details on the Prior Approval Drug Program:

www.shpnc.org/drugs-requiring-pa.html
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.
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.
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
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.
BCBSNC continues our ongoing efforts to provide education around appropriate submission of corrected claims (i.e., BlueBookSM, provider training sessions) for BlueCard members. However, we frequently receive claims indicating they are a corrected claim when no original claim is in our system.

- As a courtesy, BCBSNC has refrained from mailing these claims back to the provider. Instead, we manually process these claims as an original claim submission.

Beginning in August, we will no longer have the ability to continue this process due to a modification in the Blue Cross Blue Shield Association software. Consistent with BCBSNC’s filing requirements, we will reject and mail back corrected claims that have been submitted as corrected when no original claim is on file. Providers will be instructed to submit as a new claim.
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
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
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>
</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>
<td></td>
<td></td>
</tr>
</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
Blue Medicare HMO SM and Blue Medicare PPO SM

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.
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.
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.
The appeal process is voluntary; however, a third party (such as a provider billing agency) cannot 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, 2013*. 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.

*At release time, CMS has not ruled and made a final decision on an implementation date change for ICD-10; therefore, all documentation will reflect the original 10/1/2013 date until further updates become available.
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.

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.

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

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

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

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.

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.
“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
- CMS
- AHA
- AHIMA
  - http://www.ahima.org/icd10/
- AAPC
- NCHICA
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 Team

+ Your Provider Services team 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
SilverSneakers

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.
Thank you!

This presentation was last updated on August 13, 2012. 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.