Reminder about Blue Medicare HMO and Blue Medicare PPO products now being offered by BCBSNC

Blue Cross and Blue Shield of North Carolina (BCBSNC) wants to remind participating providers that effective April 1, 2010, Blue Medicare HMO and Blue Medicare PPO became BCBSNC product offerings. Blue Medicare HMO and Blue Medicare PPO are Medicare Advantage products offered by BCBSNC under contracts with Medicare. These products provide Medicare beneficiaries with their Original Medicare benefits plus enhanced coverage and benefits.

Blue Medicare HMO and Blue Medicare PPO products are not new products to BCBSNC. These products were formerly offered by PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS) and administered by BCBSNC. In January of this year we wrote to providers participating in the PARTNERS network to notify them of our plans to merge PARTNERS into its parent company BCBSNC. As of the merger effective date of March 31, 2010, BCBSNC now holds the contracts with Medicare to offer the Blue Medicare HMO and Blue Medicare PPO Medicare Advantage products.

Making appropriateness-of-care decisions

Blue Cross and Blue Shield of North Carolina (BCBSNC) and its associated delegates require practitioners, providers and staff who make utilization-management related decisions to make those decisions solely based on appropriateness of care and service and existence of coverage. BCBSNC does not compensate or provide any other incentives to any practitioner or other individual conducting utilization-management review to encourage denials. The plan makes clear to all staff who make utilization-management decisions that no compensation or incentives are in any way meant to encourage decisions which would result in barriers to care or service or underutilization of services.

Arranging care and handling administrative functions

Claims:
Continue to send claims for your Blue Medicare HMO and Blue Medicare PPO patients just as you have been, either electronically or by paper. Just remember that you are now sending to BCBSNC. We’ll continue to process claims at our Winston-Salem location.

If sending paper claims, mail to:
BCBSNC
P.O. Box 17509
Winston-Salem, NC 27116

Please remember to properly route your claim submissions so that claims filed to BCBSNC for Blue Medicare HMO and Blue Medicare PPO member services reach their Winston-Salem destination. Processing of claims routed to BCBSNC’s Durham office at P.O. Box 2291 will be delayed.

Provider Line Customer Service:
If you’d like to speak with Customer Service about a Blue Medicare HMO or Blue Medicare PPO related issue, call us on the Provider Line at 1-888-296-9790 — or if calling locally (336) 774-5400.

Healthcare Services:
Contacting Healthcare Services and arranging services for Blue Medicare HMO and Blue Medicare PPO members has not changed. Healthcare services can still be reached by calling either 1-888-296-9790 or if calling locally (336) 774-5400.
BCBSNC has expanded its diagnostic imaging management program for non-emergency outpatient, high-tech diagnostic imaging services to include members covered under its Medicare Advantage products.

Beginning with dates of service on and after September 1, 2010, members covered under the Blue Medicare HMO and Blue Medicare PPO plans from BCBSNC are included in the diagnostic imaging management program. Participating providers arranging and providing outpatient diagnostic imaging services for these members are required to comply with the program’s prior approval requirements for the services listed below when performed in a physician’s office, outpatient department of a hospital, or freestanding imaging center:

- CT/CTA scans
- MRI/MRA scans
- Nuclear cardiology studies
- PET scans

Prior approval can be obtained and/or confirmed online by logging onto Blue e, at https://blue-edi.bcbsnc.com, to access the Web-based application ProviderPortal® of American Imaging Management (AIM).

If you are not currently registered to use Blue e, you will need to register online at https://www.bcbsnc.com/providers/edi/bluee.cfm. BCBSNC provides Blue e to providers free of charge. Please allow two weeks for processing of your registration request. You may also request prior approval by calling AIM toll free at 1-866-455-8414.

Please note that prior approval will be required for all Blue Medicare HMO and Blue Medicare PPO members.

Your BCBSNC online Provider Manual for Blue Medicare plans has been updated to include information about the diagnostic imaging management program. Details are now available at bcbson.com via the Blue Medicare HMO and Blue Medicare PPO pages located at http://www.bcbsnc.com/providers/blue-medicare-providers/index.cfm or http://www.bcbsnc.com/content/providers/dim-training.htm.

If you currently access the AIM ProviderPortal to request prior approval for BCBSNC members, you will not need to make any changes or create an additional account. Blue Medicare HMO and Blue Medicare PPO member information became available in the AIM ProviderPortal as of August 1, 2010.

Note: Blue e is available to access AIM’s Web-based application ProviderPortal, however Blue e currently cannot be utilized to conduct other electronic transactions for the Blue Medicare HMO and Blue Medicare PPO health care plans.

If you have questions regarding the diagnostic imaging management program and its expansion to include Blue Medicare HMO and Blue Medicare PPO members, please contact your regional Network Management representative.
Medicare Advantage PPO network sharing for out-of-state Blue Cross and Blue Shield members

Blue Medicare Advantage (MA) PPO Plans, including the Blue Medicare PPO plan, participate in network sharing. This network sharing allows all Blue Cross and Blue Shield (BCBS) MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO Plan, as long as the member sees a contracted BCBS MA PPO provider. This means that if you’re a provider participating in the Blue Medicare PPO plan, you can see Blue MA PPO members from out-of-state Blue Plans. These members are eligible to receive their same in-network level of benefits – just as they would when receiving care from their network providers at home.

Claims for services will be reimbursed in accordance with your Blue Medicare PPO negotiated rate with BCBSNC.

Providers who are not participating in the Blue Medicare PPO plan are not eligible to see Blue MA PPO out-of-state members as “in-network.” Non-participating providers will receive the Medicare-allowed amount for covered services, except for urgent or emergency care. Urgent or emergency care will be reimbursed at the member’s in-network benefit level. All other services will be reimbursed at the member’s out-of-network benefit level (when out-of-network benefits are available) for nonparticipating providers.

How to recognize members from out-of-state Blue Plans participating in Blue MA PPO network sharing

The “MA” in the suitcase logo on a member’s identification card tells you that the card belongs to a member who is eligible as part of the Blue MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; but instead, to show their BCBS member identification cards.

Providers are reminded that a person’s possession of an identification card is not a guarantee of enrollment, benefits or eligibility in a Blue MA PPO plan. A member’s identification, enrollment, benefits and eligibility should always be verified in advance of providing services, except when verification is delayed because of urgent or emergency situations.

Verification is easy!

Verifying benefits and eligibility for Blue MA PPO out-of-state members is easy! Just call BlueCard® Eligibility at 1-800-676-BLUE (2583) and provide the member’s alpha prefix information, located on their Blue Plan-issued membership ID card. Blue Medicare PPO providers have the added convenience of being able to use Blue e to submit electronic eligibility requests for out-of-state Blue Plan members.

Claims administration for out-of-area MA PPO Blue Plan members

Network sharing helps make claims filing simple. After providing services to eligible members, submit claims to BCBSNC’s Durham office – right here in North Carolina. Submit electronic claims to BCBSNC under your current BCBSNC billing practices or enroll for electronic claims filing with BCBSNC. Contact BCBSNC to set up electronic billing by visiting the Electronic solutions page of the BCBSNC Web site located at: http://www.bcbsnc.com/content/providers/edi/index.htm.

If filing claims using paper forms, send claims for MA PPO out-of-state Blue Plan members to:

BCBSNC
P.O. Box 35
Durham, NC 27702

Important! Claims for services provided to MA PPO out-of-state Blue Plan members should be sent to BCBSNC. Medicare should not be billed directly.

Once you submit an MA PPO claim to BCBSNC, the claim will be forwarded to the member’s Blue Plan for benefits processing. BCBSNC will work with the member’s Blue Plan to determine eligible benefits and then send the payment directly to you.

MA PPO out-of-state Blue Plan members who see Blue Medicare PPO participating providers will pay in-network cost sharing (in-network copayments, coinsurance and deductibles). Providers may collect any applicable copayment amounts from the member at the time of service. Additionally, providers may collect from members any deductible and/or coinsurance amounts as reflected on the payment remittance for a processed claim. (Members may not be balance billed for any additional amounts.) If you have questions about a processed claim for a Blue MA PPO out-of-area member, call BCBSNC BlueCard® Customer Service for assistance at 1-800-487-5522. If you have any questions regarding the MA PPO network sharing program for out-of-area Blue Plan members, please contact your regional Network Management representative. +
An outdated appearance on some of our member identification cards in 2010

If your health care organization arranges care or provides services to Blue Medicare HMO™ and Blue Medicare PPO™ members, you'll likely see two versions of our member identification cards for the remainder of 2010. Members who were enrolled in a Blue Medicare HMO or Blue Medicare PPO plans prior to April 1, 2010 (the date of BCBSNC's merger with the former PARTNERS) retained their same PARTNERS-issued member ID cards displaying the PARTNERS business name. Members who enrolled after April 1, 2010 received new cards that display the BCBSNC name. Either way, members will carry a card that displays the product name for the plan in which they are enrolled, i.e. Blue Medicare HMO or Blue Medicare PPO.

To be sure that you have the member's most current information, request to see the member's current identification card and place a copy in a secure file for your records.

ClaimCheck® code editing

BCBSNC is continually reviewing ways to further improve our claims processing accuracy and consistency by employing the latest in proven computer technology.

We are pleased to announce BCBSNC is extending the implementation of ClaimCheck® to our Medicare Advantage Plans effective March 7, 2011. ClaimCheck is a code editing system that assists in evaluating the accuracy of submitted CPT® and HCPCS codes.

ClaimCheck uses a clinical knowledge base that results in a medically based recommendation to accept code(s) as submitted, change the codes to comply with generally accepted coding practices, or seek additional information from the physician’s office.

ClaimCheck is a product currently used by BCBSNC on its other platforms and is now being extended to our Medicare Advantage platform to further improve our claims processing accuracy. The implementation is not expected to impact how claims are submitted or the methods of claim payment, however, there is a possibility that a claim could be bundled differently, resulting in a slightly higher or lower reimbursement.

Per the terms of provider Agreements, units of service shall be determined by BCBSNC and may include specific CPT codes, bundled groups of CPT codes, specific diagnoses, and/or specific time periods. BCBSNC will use its best efforts to apply bundling logic that is consistent with industry AMA HCPCS (Level I and Level II) or CMS CCI standards in effect at the time of the date of service.

We appreciate your continued support and the quality care you provide to our members. If you have any questions or concerns please contact your regional Network Management representative.
Identifying Alpha Prefixes

Alpha prefixes help you identify the plan in which a member has enrolled, even if you do not have the member’s identification card in hand.

YPW – Blue Medicare HMO™
YPF – Blue Medicare PPO™

It’s easy to distinguish between Blue Medicare HMO members and Blue Medicare PPO members. Just look at the alpha prefix at the beginning of the member’s Blue Medicare identification number. The alpha prefix YPW lets you know that the member’s coverage type is an HMO plan, and if you see YPF, you’ll know the coverage type is PPO.

By using the member’s alpha prefix, you can tell at a glance if a member has an HMO or a PPO plan, and by submitting claims with the member’s identification code (including the fourth letter of J), we can quickly direct claims for processing, speeding up eligible payments to you.

Reminder: Always verify a member’s benefits and eligibility with BCBSNC in advance of providing scheduled services to ensure that coverage is available.

Member ID# [YPWJ12345678]

Blue Medicare Product Logos – Don’t Be Confused

Our product logos help make the Blue Medicare HMO and Blue Medicare PPO plans recognizable as being offered by BCBSNC. However, it’s important to remember that in addition to our Blue Medicare HMO and Blue Medicare PPO plans, BCBSNC also offers Blue Medicare Supplement™ plans and Blue Medicare Rx™ plans, which are separate and distinct from the Medicare Advantage offerings.

BCBSNC’s Blue Medicare Supplement products are medi-gap products that coordinate with Original Medicare (Parts A and B). Therefore, members can receive services from any Medicare-participating doctor, hospital or clinic. Providers seeing Blue Medicare Supplement members submit their claims directly to Medicare and BCBSNC receives the claim on cross-over. Blue Medicare Rx is our Medicare Prescription Drug benefit (Part D) plan, which requires use of in-network pharmacies. These products are different from Blue Medicare HMO and Blue Medicare PPO. If you are contracted to provide care for Blue Medicare HMO and Blue Medicare PPO members, it is important for you to know that Blue Medicare Supplement and Blue Medicare Rx are not included in your contractual agreement.

To learn more about Blue Medicare Rx and/or Blue Medicare Supplement visit the BCBSNC Web site at: http://www.bcbsnc.com/plans/medicareplans.cfm.

Finding an Interpreter

In North Carolina, providers can locate an interpreter to assist in communicating with Spanish-speaking and other foreign-language speaking patients through the Carolina Association of Translators and Interpreters (CATTI). CATTI is an association of working translators and interpreters in North Carolina and South Carolina and is a chapter of the American Translators Association. CATTI provides contact information of translators and interpreters within North Carolina at http://www.catiweb.org/index.htm.
Information about Blue Medicare HMO and Blue Medicare PPO is readily available on the Web. Publishing on the Web helps us ensure that the information you receive about Blue Medicare HMO and Blue Medicare PPO is the most current and accurate information available. Use our Web site to find information about prior plan approval, health care coverage options and benefits, medication formularies, network providers, provider newsletters, manuals and more!

You can find us on the BCBSNC Web site at [bcbsnc.com](http://bcbsnc.com) for “Providers,” along with the answers to your Blue Medicare HMO and Blue Medicare PPO questions.

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**Reminder for Home Infusion Therapy Providers**

Home Infusion Therapy providers became eligible as of June 1, 2010 to bill for the following HCPCS codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4087</td>
<td>Gastrostomy/jejunostomy tube, standard, any material, any type, each</td>
</tr>
<tr>
<td>B4088</td>
<td>Gastrostomy/jejunostomy tube, low-profile, any material, any type, each</td>
</tr>
<tr>
<td>B4157</td>
<td>Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit</td>
</tr>
<tr>
<td>B4172</td>
<td>Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) – home-mix</td>
</tr>
<tr>
<td>B4185</td>
<td>Parenteral nutrition solution, per 10 grams lipids</td>
</tr>
<tr>
<td>B5200</td>
<td>Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress - branch chain amino acids - premix</td>
</tr>
</tbody>
</table>
Participating providers have an easy online option for submitting Medicare Part-D vaccine claims to Medco™ – it’s eDispense™. A product of Dispensing Solutions, Inc. (DSI), eDispense Part-D Vaccine Manager is a Web-based application, that offers a solution for the submission and adjudication of claims for physician-administered Part-D vaccines covered by members’ Medicare Part-D pharmacy benefits – vaccination claims that cannot be submitted on a standard CMS-1500 medical claim form.

eDispense makes real-time claims processing for in-office administered Medicare Part-D vaccines available through its secure online access. Services offered with eDispense allow providers to quickly and electronically verify members’ Medicare Part-D vaccination coverage and submit claims to our pharmacy benefits manager, Medco, over the Internet. eDispense offers providers the ability to:

+ Verify members’ Medicare Part-D vaccination eligibility and benefits in real time
+ Advise members of their appropriate out-of-pocket expense for Medicare Part-D vaccines
+ Submit Medicare Part-D vaccine claims electronically to Medco

Office-administered vaccines eligible under a member’s Part-D pharmacy benefit are to be obtained from the administering health care provider. A member should never be requested to obtain a vaccine from a pharmacy for an in-office vaccination.

Enrollment is an easy two-step process

Step 1 – Select the authorized staff member who is most likely to be the primary user of the system to enroll the practice. This person should be prepared to provide the following information about the practice:
- Tax identification number
- National provider identifier (NPI)
- Medicare ID number
- Drug enforcement administration (DEA) number
- State medical license number


Providers can contact Dispensing Solutions directly for assistance with enrollment and claims by calling their customer support center at 1-866-522-EDVM (3386).

Provider enrollment in eDispense vaccine manager and eDispense facilitated transactions between Medco and providers are voluntary options for providers. Medicare Part-D vaccine claims eligible for electronic processing with eDispense Part-D Vaccine Manager are reimbursed according to the Medco allowance, less member liability.

BCBSNC offers network providers access to eDispense Vaccine Manager for Medicare Part-D transactions through our pharmacy benefits manager Medco Health Solutions, Inc., (Medco™) by agreement between Medco and Dispensing Solutions, Inc. (DSI).

Office-administered vaccines eligible under a member’s Part-D pharmacy benefit are to be obtained from the administering health care provider. A member should never be requested to obtain a vaccine from a pharmacy for an in-office vaccination.

Safe handling of vaccines

Disease prevention is one of the most important steps to good health. It’s always better to prevent a disease than to treat it – making vaccines an important part of patient care. By vaccinating your patients you can help to protect them from certain diseases. However, this protection can be lost or impaired if vaccines are not properly stored and handled.

Vaccines can be temperature sensitive and should be monitored for temperature increases and decreases until they are administered. Vaccines should always be transported and stored at their proper temperature. Members should never be asked to pick up vaccines from the pharmacy for transport to a provider’s office, as this may result in unsafe temperature changes.

Office-administered vaccines eligible under a member’s Part-D pharmacy benefit are to be obtained from the administering health care provider. A member should never be requested to obtain a vaccine from a pharmacy for an in-office vaccination.

Office-administered vaccines eligible under a member’s Part-D pharmacy benefit are to be obtained from the administering health care provider. A member should never be requested to obtain a vaccine from a pharmacy for an in-office vaccination.

Office-administered vaccines eligible under a member’s Part-D pharmacy benefit are to be obtained from the administering health care provider. A member should never be requested to obtain a vaccine from a pharmacy for an in-office vaccination.
Information for durable medical equipment suppliers – change in BCBSNC Medicare Advantage covered services

Effective January 1, 2011, BCBSNC Medicare Advantage products no longer cover certain Durable Medical Equipment (DME) that is not covered by Medicare. Therefore, effective January 1, 2011 BCBSNC will no longer reimburse for the following Durable Medical Equipment previously identified in your contract as “Items Non-Covered by Medicare, Covered by BCBSNC.”

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A6534</td>
<td>Gradient compression stocking, thigh high, 30-40 mmhg, each</td>
</tr>
<tr>
<td>A6535</td>
<td>Gradient compression stocking, thigh high, 40-50 mmhg, each</td>
</tr>
<tr>
<td>A6537</td>
<td>Gradient compression stocking, full length/ chap style, 30-40 mmhg, each</td>
</tr>
<tr>
<td>A6538</td>
<td>Gradient compression stocking, full length/ chap style, 40-50 mmhg, each</td>
</tr>
<tr>
<td>A6540</td>
<td>Gradient compression stocking, waist length, 30-40 mmhg, each</td>
</tr>
<tr>
<td>A6541</td>
<td>Gradient compression stocking, waist length, 40-50 mmhg, pair</td>
</tr>
<tr>
<td>A6544</td>
<td>Gradient compression stocking, garter belt, each</td>
</tr>
<tr>
<td>E0245</td>
<td>Tub stool or bench, each</td>
</tr>
</tbody>
</table>

Referrals to suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

Blue Cross and Blue Shield of North Carolina (BCBSNC) requests your assistance with protecting our Blue Medicare HMO™ and Blue Medicare PPO™ members and ensuring that you refer them to DMEPOS suppliers that are within the BCBSNC Medicare Advantage network. Claims submitted for medical supplies and/or services from non-participating DMEPOS suppliers will result in non-payment for HMO members and may result in higher out of network costs for PPO members, even if the provider is Medicare certified.

BCBSNC offers a simple tool designed to assist physicians and members with locating in-network health care providers. Visit us at: [http://www.bCBSnc.com/apps/providers/search.do?searchType=Doctor](http://www.bCBSnc.com/apps/providers/search.do?searchType=Doctor). With this tool you will have the ability to obtain a complete listing of participating Blue Medicare HMO and Blue Medicare PPO DMEPOS suppliers. Simply begin your search by selecting the member’s health plan from the drop-down box followed by the health provider’s specialty. Additional options are available to help narrow the search.

Utilizing the provider search tool only takes a few moments and ensures our Blue Medicare HMO and Blue Medicare PPO members are referred to participating DMEPOS suppliers who have met the high quality standards our members/patients have come to expect.

Changes to Prolonged Care Services for Year-2010

Current Procedural Terminology (CPT) revised the guidelines for prolonged services without direct face-to-face patient contact (CPT 99358 - 99359), when filed in addition to the primary evaluation and management of care. When eligible, payment for these services will be included in the reimbursement for direct face-to-face services billed by physicians. Physicians cannot bill the member when covered services and payment are included in the reimbursement for other billable services.
Blue Cross and Blue Shield of North Carolina (BCBSNC) would like to clarify the proper filing procedure for CPT 90715—Tetanus, diphtheria toxoids and acellular pertussis (Tdap) for Blue Medicare HMO and Blue Medicare PPO covered patients. Tdap is a covered benefit under a member’s Medicare Part D benefit. Medicare coverage guidelines do not allow for reimbursement under the Part B medical benefit. Therefore, any claim submitted for CPT 90715 under the Part B medical benefit will be denied and providers will be required to re-submit a new claim under the member’s pharmacy benefit.

ARRA allows members to self-pay for privacy

If a Blue Medicare HMO™ and Blue Medicare PPO™ member pays the total cost of medical services and requests that a provider keep the information confidential, the provider must abide by the member’s wishes and not submit a claim to BCBSNC for the specific services covered by the member. In accordance with section 13405, “Restrictions on Certain Disclosures and Sales of Health Information,” of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (ARRA) and any accompanying regulations, you may bill, charge, seek compensation or remuneration or collection from the member for services or supplies that you provided to a member – if the member requests that you not disclose personal health information to us, and provided the member has paid out-of-pocket in full for such services or supplies. Unless otherwise permitted by law or regulation, the amount that you charge the member for services or supplies in accordance with section 13405 of ARRA may not exceed the allowed amount for such service or supply.

Additionally, you are not permitted to (i) submit claims related to, or (ii) bill, charge, seek compensation or remuneration or reimbursement or collection from us for services or supplies that you have provided to a member in accordance with section 13405 of ARRA. +

Your provider data

Addresses, phone numbers and a current list of all providers at your health care location(s) are routinely made available to Blue Medicare HMO and Blue Medicare PPO members via our online provider directories so that members can quickly locate you and schedule appointments. Having accurate mailing information on file for your health care business also ensures that you receive claim payments and other important correspondence from us in a timely manner. Our ability to direct members to you for their medical care depends on the accuracy of the information that we have on file for your health care facility and/or practice.

Network Management should be notified whenever there’s a change of ownership, name and/or tax identification to your health care organization. In addition, Network Management should be notified about any opening, closing, and/or relocation of a practice site. Changes in services may also require that you notify Network Management – for example, a home health agency adding home infusion therapy services would need to notify Network Management. If in doubt, please call us!

To ensure that we provide our members with the most current information related to your organization, please report any practice- and/or facility-related changes to your regional Network Management field representative or complete and return a provider “Demographic Form,” which can be found on the “Providers” page on our Web site at http://www.bcbsnc.com/assets/providers/public/pdfs/Provider_Update.pdf.

When using the online form be sure to respond to the email address link listed as MParkBIU@bcbsnc.com, located on the lower portion of the form. +

Clarification for filing CPT 90715 (Tdap) for Blue Medicare HMO and Blue Medicare PPO members

Blue Cross and Blue Shield of North Carolina (BCBSNC) would like to clarify the proper filing procedure for CPT 90715—Tetanus, diphtheria toxoids and acellular pertussis (Tdap) - for Blue Medicare HMO and Blue Medicare PPO covered patients. Tdap is a covered benefit under a member’s Medicare Part D benefit. Medicare coverage guidelines do not allow for reimbursement under the Part B medical benefit. Therefore, any claim submitted for CPT 90715 under the Part B medical benefit will be denied and providers will be required to re-submit a new claim under the member’s pharmacy benefit.

Remember, providers enrolled in eDispense™ – a product of Dispensing Solutions, Inc., (DSI) – can submit Medicare Part D vaccine claims electronically to Medco® for direct reimbursement. Contact DSI directly for assistance with enrollment and claims by calling their customer support center at 1-866-522-EDVM (3386). +
Have you heard about the Blue Medicare HMO℠ and Blue Medicare PPO℠ Case Management Programs?

At BCBSNC, we have Case Management programs for:
+ Congestive Heart Failure (CHF)
+ Chronic Obstructive Pulmonary Disease (COPD)
+ Diabetes
+ Patients who have multiple or sufficiently severe chronic conditions
+ Patients who need assistance with the management of their health care needs

Our nurses with expertise in chronic conditions provide telephonic monitoring and interventions to participating patients. Through our programs, our specially trained nurses:
+ Monitor and assess patient symptoms
+ Provide education to the patients and/or their caregiver about their chronic conditions and co-morbidities, lifestyle choices and medications
+ Communicate and collaborate with the patients’ families and physicians
+ Provide information regarding community resources to help patients better manage their health

Together with patients’ physicians and other health care providers, Blue Medicare Case Management programs empower individuals to effectively manage chronic illness and prevent complications.

Providing early assessment and timely interventions can make a difference in the health outcomes of our patients.
Patient participation is voluntary, and best of all, there is no cost to the patient.

For more information, or to refer one of your patients to our program, please contact us at 1-800-942-5695, ext. 14386 or 14002, Monday through Friday 8 a.m. – 5 p.m. +

Primary care physicians with patients enrolled in BCBSNC case management programs

At Blue Cross and Blue Shield of North Carolina (BCBSNC), the primary care physician-patient relationship for our members begins at the time the member selects or is assigned a physician to be his or her primary care physician and coverage for medical services becomes effective. From that time on, unless the relationship is terminated, the physician is responsible for providing necessary medical care, including emergency care (when appropriate for the member’s condition and situation). This includes a member who is new to a practice, even if the patient has not made previous contact with that office.

Elected or assigned primary care physicians may have patients identified by BCBSNC as having a chronic disease state for which BCBSNC has a case management program. Primary care physicians with “high risk” patients enrolled in these programs may receive faxed communications from a case management nurse regarding a member’s clinical condition. The communication highlights symptoms reported and clinical notes. In some instances, a case management nurse may contact the primary care physician directly depending on the severity of the situation. This is not typical but may be deemed necessary in the event:
+ A member’s condition has changed and warrants review by a physician
+ The nurse discovers something the physician needs to be aware of for optimal treatment of the member

BCBSNC will notify the member when a physician has been sent clinical information. If the member has had no previous contact with the practice, it is recommended the primary care physician make contact with the member before ordering or referring services.
The BCBSNC pre-service department reviews requests for coverage of medical services and Part D drugs that are on the prior approval list. When the review results in the non-authorization of coverage for the service or drug, BCBSNC notifies the requestor of the outcome. If the requesting provider submits additional clinical information after the decision has been communicated, the additional information can be processed as an appeal or reconsideration when the additional information includes an appeal letter signed by the physician or prescription drug prescriber. Otherwise, the additional information will not be reviewed. As defined by the Centers for Medicare & Medicaid Services (CMS), “Reconsideration is an enrollee’s first step in the appeal process after an adverse organizational or coverage determination; a Medicare health plan or independent review entity may reevaluate an adverse organization or coverage determination, the findings upon which it was based and any other evidence submitted or obtained.”

If a medically necessary adverse organizational or coverage determination has been made and communicated by BCBSNC, providers and/or members should follow the appeals process as outlined in the adverse organizational/coverage determination letter, which will be provided by us. Submission of additional clinical documentation by the provider will be considered by BCBSNC to be a reconsideration/appeal request when any of the following are true:

+ The request is for the same service and is accompanied by a written appeal request signed by the physician or prescription drug prescriber.
+ The additional clinical documentation is received by the BCBSNC within sixty days of the adverse organizational/coverage determination being communicated and is accompanied by a written appeal request signed by the member’s physician or prescription drug prescriber.
+ An appeal has already been initiated and is still under review.

**Medical and drug coverage of insulin and associated supplies for insulin injection**

The Centers for Medicare & Medicaid Services (CMS) requires that drugs prescribed for conditions that could potentially be covered under either a patient’s Medicare Part B Medical benefit or Part D Prescription Drug benefit be paid under the correct benefit. As part of our effort to comply with this requirement we conduct periodic retrospective audits of claims. Results of our audit show errors in billing and payments associated with coverage for insulin and supplies associated with the injection of insulin. If you are a provider administering insulin to BCBSNC members, please review the following criteria requirements for billing and receiving payment for insulin and supplies associated with the injection of insulin:

**Coverage of Insulin as a Part B Medical benefit:**

+ Insulin administered via insulin pump (if medically necessary).

**Remainder:** Please note that not all members have elected to enroll in a Part D prescription drug benefit.

Coverage of Insulin and supplies as a Part D Prescription Drug benefit:

+ Insulin injected via syringe by the beneficiary in the home.
+ Medical supplies associated with the injection of insulin.
  - “Medical supplies associated with the injection of insulin and insulin injection delivery devices not otherwise covered under Medicare Part B, such as insulin pens, pen supplies and needle-free syringes, can satisfy the definition of a Part D drug (as defined in regulations of the Secretary).” CMS defines those medical supplies to include syringes, needles, alcohol swabs and gauze.

In order to facilitate reimbursement under the appropriate benefit, please notify your staff of the information above. Your assistance in documenting if a member is receiving insulin via a pump or via injection will minimize delays in filling these prescriptions and help ensure that the drug is covered under the correct benefit.

References:

- Medicare Part B versus Part D coverage issues [http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf)
Coverage review for rental DME

Original Medicare medical necessity criteria and/or BCBSNC coverage guidelines are used in the coverage review of all rental durable medical equipment (DME) items for Blue Medicare HMO® and Blue Medicare PPO® members. BCBSNC considers months with previous Medicare plans (Original Medicare, Medicare Advantage or other Medicare plans) in calculating the rental period. To assist with understanding how rental period time-calculation are made, we’ve developed the following explanation in a “questions and answers” format:

Q. Does BCBSNC apply toward a DME rental period the monthly rental payments that were paid by Original Medicare or another Medicare Advantage plan, prior to a member enrolling in a BCBSNC Blue Medicare HMO or Blue Medicare PPO plan?
A. Yes, BCBSNC does count the monthly rental payments made by Original Medicare or another Medicare Advantage plan prior to a member joining a Blue Medicare HMO or Blue Medicare PPO plan.

Q. An oxygen rental period lasts up to 36 months. When a 36-month rental period ends, who owns the equipment and who pays for needed maintenance and supplies?
A. If the oxygen was capped (36-months) in the calendar year 2008 the member owns the equipment. However, if the oxygen was capped (36-months) in the calendar year 2009 or afterwards, the vendor retains ownership of the oxygen equipment. Since the vendor owns the oxygen equipment, members will no longer pay a monthly coinsurance amount. The vendor can no longer bill the plan for the rental fee but may bill for repairs when prior approval is obtained from BCBSNC.

Q. Will BCBSNC continue to pay for refilling of the oxygen contents once the 36-month rental period is over?
A. Yes. There are specific Healthcare Common Procedure Coding System (HCPCS) E codes for oxygen contents that are eligible for payment, once per month (every 25 days). After the cap is reached, content billing codes are set up to pay automatically E0441, E0442, E01443 and E0444. Providers may bill one unit per month for the concentrator and one unit per month for the portable oxygen.

Q. How does BCBSNC handle oxygen equipment replacement?
A. During the rental period (36-months) if the oxygen equipment is irreparable the provider is expected to replace the oxygen equipment. The 36-month rental period would not be interrupted, continuing until the 36-month capped rental is reached.

If the vendor-owned oxygen equipment is irreparable after the 36-month capped rental period has been met, but prior to the 60-month useful lifetime of the oxygen equipment, the vendor is responsible for providing new oxygen equipment. The rental period does not start over and no additional rental payments will be authorized.

If the member-owned oxygen equipment (reached 36-month capped rental in 2008) is irreparable after the 36-month capped rental has been met, but prior to the 60-month useful lifetime of the oxygen equipment, BCBSNC will begin another 36-month capped rental period if prior approval has been authorized by us.

Once the 60-month useful lifetime of the equipment has been reached and the member requests to receive new equipment, the vendor (after obtaining prior approval from BCBSNC) may deliver new equipment and begin billing a new 36-month rental period. The member must be informed by the vendor that the coinsurance associated with a new 36-month rental will resume with the delivery of the new equipment.

Q. Does the reasonable useful lifetime of equipment (60-months / 5-years) restart if equipment is replaced or is the “lifetime” based on the initial date of service?
A. The useful lifetime of oxygen equipment does not restart due to changes in modality or specific pieces of equipment; the expected useful lifetime is based on the initial date that a member received the equipment.

Q. May suppliers start a new 36-month rental period when they provide new equipment to patients who have had their current equipment greater than 60-months?
A. Yes, a supplier may provide new oxygen equipment once the useful lifetime (60-months / 5-years) has elapsed but only if the equipment is requested by the member and prior approval has been obtained (by the supplier) from BCBSNC. Suppliers may not arbitrarily issue new equipment.

Q. When are BCBSNC DME policies typically updated and how are providers notified?
A. DME policies are reviewed and updated annually or sooner if there is a medical coverage policy update from CMS. Blue Medicare HMO and Blue Medicare PPO coverage policies are published on our Web site for providers at: bcbsnc.com/content/providers/blue-medicare-providers/index.htm.

Additional detail about Original Medicare Guidelines for DME rental is available on the Center for Medicare and Medicaid Services Web site located at: www.cms.hhs.gov. +
Medical coverage policy updates available online

Care Management & Operations, Medicare C/D* provides online access to Blue Medicare HMO and Blue Medicare PPO medical coverage policies along with applicable CPT/HCPCS codes.

Medical coverage policies are developed after review of current Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs)/Local Coverage Determinations (LCDs), standard of care literature/research, and recommendations from physician specialists.

Updates to the medical coverage policies and corresponding codes are made available on the Blue Cross and Blue Shield of North Carolina (BCBSNC) Web site for providers at: http://www.bcbsnc.com/content/providers/blue-medicare-providers/medical-policies and http://www.bcbsnc.com/assets/services/public/pdfs/bluemedicare/prior_approval/cpt_codes.pdf.

*C/D – Medicare Part C/ Medicare Part D

Network management is available for you!

Network Management is responsible for developing and supporting relationships with the provider community. Network Management staff is dedicated to serving as a liaison between you and BCBSNC and is available to assist you with a variety of issues, including:

+ Questions regarding contracts, policies and procedures
+ Changes to your organization including:
  - Opening/closing locations
  - Change in name or ownership
  - Change in tax ID number, address or phone number
  - Merging with another group
  - Educational needs

Network Management staff members are located throughout the state and are assigned to support the provider community by specific geographical region. Please contact one of our Network Management offices whenever you need our assistance.

Network Management Contact Information

Charlotte Area (800) 754-8185
Greensboro – Winston Salem Area (888) 298-7567
Greenville Area (888) 291-1780
Hickory Area (877) 889-0002
Raleigh Area (800) 777-1643
Wilmington Area (877) 889-0001

New and revised policies

The Medicare Advantage Quality Improvement Committee and Medicare Advantage Physician Advisory Group reviewed and approved the following Medical Coverage Policies. These policies have been updated since the last provider newsletter.

The following is a listing of the new and revised policies for the BCBSNC Blue Medicare HMO and Blue Medicare PPO products:

**Revised Policies**

- Ambulance Transport
- Breast Implant Removal
- Breast Reduction
- Clinical Trials
- Deep Brain Stimulation
- Dental Hospital
- Dental Services
- Dermabrasion
- Durable Medical Equipment
- Electrical Stimulator: Bone Growth
- Electrical Stimulator: Neuromuscular
- Electrical Stimulator: Spinal Cord
- Electrical Stimulator: TENS
- Epogen/Procrit Medications
- External Infusion Pumps
- Intravenous Immunoglobulin (IVIG) Medication
- Investigational (Experimental) Services
- Lung Volume Reduction Surgery
- Lymphedema Pumps-
  - Pneumatic Compression Device
- MOHS Surgery
- Morbid Obesity Surgery
- Nebulizer Medications
- Neuropsychological Testing
- Observation
- Obstructive Sleep Apnea
- Oral Chemotherapy Medications
- Orthognathic Surgery
- Penile Implants
- Psychological Evaluations
- Refractive Surgical Procedures
- Sacral Nerve Stimulation
- Skilled Care Services
- Speech Language Pathology
- TMJ Surgery
- Treatments for Obstructive Sleep Apnea and Breathing Related Sleep Disorders
- Vagus Nerve Stimulation
- Varicose Veins
- X-Stop

**New Policies**

- Cataract Extraction
- Investigational (Experimental) Services

If after reading about a specific policy on our Web site you still have questions, please contact the Care Management & Operations-Medicare C/D* department at 1-888-296-9790.
Blue Cross and Blue Shield of North Carolina (BCBSNC), has expanded its Blue Medicare HMO and Blue Medicare PPO network to five additional North Carolina counties — Cleveland, Union, Montgomery, Scotland and Wilson.

Blue Medicare HMO and Blue Medicare PPO Medicare Advantage plans offer lower out-of-pocket costs and more benefits than traditional Medicare, including preventive care and routine vision care.

Employer groups became eligible to purchase the plans in these counties beginning August 1, 2010, while individuals in these counties can begin purchasing the plans starting November 15, 2010, for a January 1, 2011 effective date.

Blue Medicare HMO and Blue Medicare PPO products are available in the above shown highlighted counties.

Prior Authorization Guidelines
Revisions effective January 1, 2011

January 1, 2011 the Prior Authorization Guidelines are being updated with the following changes.

Services removed from prior approval:

+ Extracapsular cataract extraction with intraocular lens
+ MOHS surgery

These procedures, if performed with a date of service after January 1, 2011 will not require prior authorization from BCBSNC.

Clarifications:

+ Surgery for penile implants moved under surgery header
+ Durable medical equipment (DME) maintenance and repair is listed as a separate item

Please review the guidelines carefully to ensure that the services on the list are prior approved before service is provided to a member. A copy of the revised guidelines is included in this newsletter.


Additionally, specific codes requiring prior approval are located at http://www.bcbsnc.com/content/providers/blue-medicare-providers/prior_approval/approval.htm.

If you have questions regarding the Prior Approval Guidelines please contact your regional Network Management representative for assistance.
As a physician with older adult patients, you know that aging brings with it a great deal of change, in both mind and body. As we age, we often face physical health issues such as cardiovascular failure and broken bones. Getting older can also cause mental changes such as lack of sharpness and fading memory. All of these changes can be alarming to older adults, especially when unprepared for this next phase of life.

The good news is many of these ‘symptoms’ of old age can be prevented and treated with a simple prescription: healthy eating and regular exercise. By advising your patients about the realities of aging and providing them with proactive advice, you can help them maintain optimal health. As you educate your patients about the importance of including regular physical activity in their weekly routines, be sure to remind them that as Blue Medicare HMO and Blue Medicare PPO members, the SilverSneakers Fitness Program is available to them.

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.

Older adults can face challenges that can be positively impacted by healthy lifestyle changes:

**Slight forgetfulness or dementia**
As people age, their brain’s volume gradually shrinks. When this occurs, some of the nerve cells in the brain can shrink or lose connections with other nerve cells. In addition, blood flow within the brain slows somewhat in old age. For this reason, most seniors experience some degree of forgetfulness, with some suffering from dementia or even Alzheimer’s disease.

**Get social**
People who are more socially and intellectually engaged have a lower risk of developing dementia. Programs such as the Healthways SilverSneakers® Fitness Program are a great way for seniors to expand their social networks and interact socially on a regular basis, all while getting physically fit.

**Bone loss**
Seniors’ bones can become thinner and more brittle, putting them at a higher risk for osteoporosis and falls.

**Pump iron**
Increased physical activity reduces seniors’ risk of falling and fracturing bones. Low-impact exercises are often the best choice, especially when coupled with weight-bearing exercises. SilverSneakers exercises can improve your patients’ balance, flexibility and coordination, keeping them steady on their feet.

**Digestive trouble**
Aging muscles contract more slowly, and the same goes for digestive muscles. This change can lead to problems such as constipation and stomach pain.

**Eat well**
Remind your patients that a healthy, well-balanced diet, including foods that are rich in fiber, low in fat and cholesterol can help soothe digestive troubles.

**Heart disease**
With age, some seniors experience enlargement of the heart and thickening of the coronary walls.

**Move it**
Doing 30 to 60 minutes of moderate physical activity most days of the week can improve heart health. SilverSneakers offers a number of classes aimed at motivating older adults to commit to consistent exercise.
HealthTrio connect™

BCBSNC, together with HealthTrio™ connect, utilizes the power of the Internet to deliver a comprehensive suite of administrative transactions – all with secure messaging to enable HIPAA-compliant communication.

HealthTrio connect allows you to perform the following easily, from your desktop and in real-time:

+ Check claim status
+ View an explanation of payment (EOP) of a processed claim or claims
+ Verify member eligibility and benefits information
+ Check referral status
+ Obtain provider demographics

HealthTrio connect streamlines many office management tasks that have traditionally been paper-based or done by phone. To find out more about HealthTrio connect and how to connect for your office, visit us on the Web at http://www.bcbsnc.com/content/providers/blue-medicare-providers/electronic-commerce/index.htm or call BCBSNC Provider Services at 1-888-296-9790.

Important Message for Providers Who Participate With BCBSNC and Utilize Blue e™

HealthTrio connect™ is the secure Internet site for conducting electronic transactions with BCBSNC for the Blue Medicare HMO™ and Blue Medicare PPO™ products. It’s important to note that you cannot conduct transactions for Blue Medicare HMO or Blue Medicare PPO™ using Blue e™ (with the exception of using Blue e to access AIM’s Web-based application ProviderPortal™ and when verifying eligibility for out-of-state Blue Plan PPO members).

The Blue e system will reject claims activity for Blue Medicare HMO and Blue Medicare PPO.