



BlueLinkSM

News from Blue Cross and Blue Shield of North Carolina

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Inside:

Inter-Plan Programs:
updates and reminders..... 1

HIPAA 5010 transactions
and code sets..... 6

Healthcare Management and
Operations..... 9

BCBSNC member rights
and responsibilities..... 20

2011 Annual Provider
Conferences 24

- Physicians/Specialists
- Facilities/Hospitals
- Ancillary
- Pharmacy

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

bcbsnc.com



**BlueCross BlueShield
of North Carolina**

Inter-Plan Programs: Updates and Reminders



Coordination of Benefits (COB) questionnaire available for BlueCard[®] members

If you have a Blue Cross and/or Blue Shield BlueCard member who you believe may have other health insurance coverage, you can now present them with a COB questionnaire during their visit.

Collecting COB information from members before you file their claim eliminates the need to gather this information later, thereby reducing processing and payment delays. You can download and print a copy of the COB questionnaire by accessing the Links section on *Blue e* or on our Web site located at bcbsnc.com/content/providers/coordination-of-benefits.htm.

Please provide members with a copy of the questionnaire during their visit and ask them to complete the form and send it to their Blue Plan, the Blue Plan through which they are covered, as soon as possible after leaving your office. The mailing address for the member's plan can be found on the back of their member ID card, or by calling the customer service number also listed on the back of the card.

*It is important that the **member** signs and dates the COB questionnaire form prior to submitting to their Home plan.

Guide to Blue Cross and/or Blue Shield Member ID Card

Alpha Prefix

The majority of Blue-branded ID cards display a three-character alpha prefix in the first three positions of the subscriber's ID number. However, there are some exceptions to this; ID cards for the following products/programs do not have an alpha prefix:

- Stand-alone vision and pharmacy when delivered through an intermediary model*
- Stand-alone dental products*
- The Blue Federal Employee Program (FEP) – has the letter "R" in front of the ID number*

*Follow instructions on these ID cards on how to verify eligibility, submit claims and who to contact with questions.

(continued on page 2)

The alpha prefix is critical for any inquiries regarding the member, including eligibility and benefits, and is necessary for proper claim filing. When filing the claim, always enter the ID number exactly as it appears on the member's card, inclusive of the alpha prefix, and include this complete identification on any documents pertaining to services to ensure accurate handling by the Blue Plan.

A correct member ID number includes the alpha prefix, in the first three positions, and all subsequent characters, up to a total of 17 positions. Thus, you may see cards with ID numbers consisting of the alpha prefix followed by between six and 14 numbers/letters. The following are examples of ID numbers showing the alpha prefix:

ABC1234567	ABC1234H567
Alpha Prefix	Alpha Prefix
ABCD1234H567	ABCD1234H56789012
Alpha Prefix	Alpha Prefix

Below is an example of a Blue ID card with the alpha prefix highlighted:

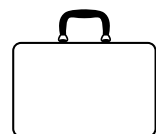
		Blue Product	ALPHA Employer Group
Member Name: Member Name Member ID: XYZ123456789		Dependents: Dependent One Dependent Two Dependent Three	
Group No.	023457	Plan	PPO
BIN	987654	Office Visit	\$15
Benefit Plan	HIOPT	Specialist Copay	\$15
Effective Date	00/00/00	Emergency	\$75
Plan Code	123	Deductible	\$50

Benefit Product Logos

Below are various logos that may be displayed on member ID cards for Blue Cross and/or Blue Shield Plans in the United States and for International Licensees licensed through BCBSA. Member ID cards may include one of several logos identifying the type of coverage the member has and/or indicating the provider's reimbursement level.

Tips for Success

The appearance of a benefit product logo is not a guarantee of payment. A provider's reimbursement is based upon a combination of what services are covered under the member's benefit plan in conjunction with a provider's contract(s) with BCBSNC.



Blank (empty) Suitcase

A blank (empty) suitcase logo on the front of a member's ID card signifies that the member has out-of-area coverage that is not a PPO product. Benefit products that display a blank (empty) suitcase logo on ID cards include:

- Traditional
- HMO (Health Maintenance Organization)
- POS (Point of Service)
- Limited benefits products

Traditional, HMO and Limited Benefit Products Members

If you have a traditional/indemnity contract with BCBSNC and provide medical service to a member who has a blank suitcase logo on his/her member ID card (local member or out-of-area member) you will be reimbursed for services covered under the member's benefit plan, in accordance with the traditional/indemnity contract.

Tips for Success

Because there are different benefit plans represented by the blank (empty) suitcase logo, always verify eligibility and benefits electronically with BCBSNC or by calling **1-800-676-BLUE** (2583).



PPO in a Suitcase

When you see the “PPO in a suitcase” logo on the front of the member’s ID card, it means that the member has PPO (Preferred Provider Organization) or EPO (Exclusive Provider Organization) type benefits available for medical services received within or outside of the United States. It also means that the provider will be reimbursed for covered services in accordance with the provider’s PPO contract with the local Blue Plan.

No Suitcase

Some Blue ID cards do not have any suitcase logos on them. This includes ID cards for Medicaid, State Children’s Health Insurance Programs (SCHIP) administered as a part of a state’s Medicaid program, Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products.

Tips for Success

While BCBSNC routes all of these claims for out-of-area members to the member’s Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member’s Blue Plan via the established electronic Medicare crossover process.

Automatic Crossover for all Medicare Claims

All Medicare crossover claims are automatically submitted to the secondary payor. So, after your claim has been filed to Medicare, you do not need to file a second claim to BCBSNC. (Automatic crossover applies to both local BCBSNC claims and IPP BlueCard claims.) All Blue Plans crossover Medicare claims for services covered under Medigap and Medicare Supplemental products are automatically submitted to the Blue secondary payor, reducing or eliminating the need for the provider’s office or billing service to submit an additional claim to the secondary carrier. Additionally, as all Blue Plans are participating in this process, Medicare claims will crossover in the same manner nationwide.

Whether the secondary payor is BCBSNC or another Blue Plan, you only need to file the claim once and the claim will be automatically routed for secondary processing.

This Medicare crossover process applies to all provider types, including: hospitals and facilities, professional providers, ancillary providers, federally qualified health centers, rural health clinics and comprehensive outpatient rehabilitation facilities. Federally qualified health centers, rural health clinics and comprehensive outpatient rehabilitation facilities can now bill Medicare using a UB-04 claim form without submitting a second CMS-1500 claim form to BCBSNC.

Claims Filing

For members with Medicare primary coverage and BCBSNC or another Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier. There is no need to submit a second claim to BCBSNC or another Blue Plan.

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

When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. Be sure to distinguish if the Plan is BCBSNC or a different Blue Plan. Check the member’s ID card for additional verification.

- If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to BCBSNC.
- If the remittance indicates that the claim was not crossed over, submit the claim to BCBSNC with the Medicare remittance information.

Be certain to include the alpha prefix as part of the member identification number. The member’s ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and crucial in facilitating prompt payments.

(continued on page 4)

Payment time

The claims you submit to the Medicare intermediary will be crossed over to BCBSNC or the out-of-state Blue Plan after they have been processed by the Medicare intermediary. This process may take up to 14 business days. This means that the Medicare intermediary will release the claim to BCBSNC or the out-of-state Blue Plan for processing at about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14 to 30-business days for you to receive payment from BCBSNC or the out-of-state Blue Plan.

Claims questions?

Answers to questions about claims that have crossed over can be found by accessing *Blue e* or by calling the Provider Blue Line at **1-800-214-4844** (for BlueCard® claims, call **1-800-487-5522**).

If there is a delayed response

If you submitted the claim to the Medicare intermediary/ carrier and have not received a response to your initial claim submission, do not automatically submit another claim. Rather, you should:

- Review the automated resubmission cycle on your claim system.
- Wait 30 days.
- Check claims status before resubmitting (sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and can create confusion for the member).

Go online to view out-of-area Blue members' medical policies and pre-certification requirements

Go online to view out-of-area Blue members' medical policies and pre-certification requirements

BCBSNC is excited to tell you about a new online tool available via our Provider Portal at bcbsnc.com/providers on the Medical Policy and Precertification/Preauthorization Router page. This new feature is designed to make it easier for our health care partners to find information when treating out-of-area Blue Plan members.

You 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. Please note: The router is not applicable to patients enrolled in Medicare Advantage Plans or the Federal Employee Program.

Online instructions:

1. Log on to bcbsnc.com/providers.
2. Go to the center of the page, under Provider Resources.
3. Select the link: Out of State Blue Plans: Medical Policy & Prior Approvals/Authorization.

BlueCross BlueShield of North Carolina

I'm a provider

Provider Portal

News and Updates

- [A guide for dental care providers](#)
- [Stick it to the flu](#)
- [Leading the way on health care reform](#)
- [See resources and information for Blue Medicare HMO SM and Blue Medicare PPO SM providers](#)
- [Diagnostic imaging management program](#)
- [Important news affecting our providers](#)

Provider Resources

[Provider Demographic Form](#)

Some of the most widely used resources and information specifically for BCBSNC providers in one convenient location.

- [Download provider directory](#)
- [Medical policy search](#)
- [Find a drug](#)
- [Find a doctor](#)
- [File a claim](#)
- [Make an online inquiry](#)
- [Download Medicare payer sheets](#)
- [Download provider credentialing applications](#)
- [Important news](#)
- [Ambulance Trip Notes Form](#)
- [Clinical practice and preventive health guidelines](#)
- [Prior approvals and authorization](#)
- [Access to care standards](#)
- [Providers Serving Out-of-State Blue Cross and/or Blue Shield Medicare Advantage Members](#)
- [Update your provider information](#)
- [Coordination of benefits questionnaire for BlueCard® members now available](#)
- [Provider toolkits](#)
- [E-Visit attestation form and reimbursement overview](#)
- [Out of State Blue Plans: Medical policy & Prior Approvals/Authorization](#)
- [Provider Update Form](#)

Medical Policy & Prior Approvals/Authorization

(continued on page 5)

4. You will then be routed to Medical Policy Precertification/Preauthorization information for out-of-area members.

The screenshot shows the BlueCross BlueShield of North Carolina website. At the top right, there are navigation links: "About BCBSNC", "Find a doctor", "Find a drug", "Careers", and "Contact us". The BlueCross BlueShield logo is on the left. A search bar is located on the right. Below the logo, there is a sidebar menu with options: "I'm a provider", "Providers home", "Dental Providers", "Important news", "Legislative Resources", "Appeals", and "Blue Medicare HMO and PPO providers". The main content area is titled "Medical Policy and Pre-certification/Pre-authorization Information for Out-of-Area Members". It contains a blue box with instructions: "To view the out-of-area Blue Plan's medical policy or general pre-certification/pre-authorization information, please select the type of information requested, enter the first three letters of the member's identification number on the Blue Cross Blue Shield ID card, and click 'GO'." Below this, there are radio buttons for "Medical Policy" and "General pre-certification/pre-authorization information". There is an "Alpha Prefix" input field and a "Go" button. At the bottom, it says "If you experience difficulties or need additional information, please contact 1.800.676.BLUE."

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

1. Select the type of information requested.
2. Enter the patient's three-letter alpha prefix that precedes the ID number, and click GO.
3. You will then be routed to the Home Plan's medical policy and/or prior review requirements.
4. Once medical policy and prior review requirements are viewed, you will then be reconnected back to the BCBSNC Web site.

We hope this new Web functionality gives you easy access to the information you need and provides a valuable supplement to the information you currently receive when verifying patients' benefits and eligibility.

If you have questions regarding the Medical Policy and Precertification/Preauthorization Router, please contact your regional Strategic Provider Relationship Consultant.

BlueCard® Ancillary Claim Filing

Ancillary claims for Independent Clinical Laboratory, Durable/Home Medical Equipment and Supply, and Specialty Pharmacy are filed to the Local Plan in whose service area the ancillary services were rendered - if these services were performed in North Carolina, the Local Plan is BCBSNC.

Local Plan	
Lab	The Plan in whose Service Area the specimen was drawn.
DME	The Plan in whose Service Area the equipment was shipped to or purchased at a retail store.
Specialty Pharmacy	The Plan in whose Service Area the ordering physician is located.

Note: Claims are determined to be in- or out-of-network based on the rendering provider's local plan's provider contracting arrangement.

HIPAA 5010 Transaction & Code Sets

HIPAA Version 5010 migration is underway with the 01/01/2012 implementation date rapidly approaching. In order for all Covered Entities to be ready within the implementation timelines, BCBSNC would like to re-emphasize key dates. The implementation timeline for all Covered Entities is as follows:

- Roll Out/Dual Use = 01/01/2011 - **12/31/2011**
- Compliance/HIPAA 5010 Only = **01/01/2012**

The last day BCBSNC will accept a 4010 Transactions is 12/31/2011. Starting 01/01/2012 we will reject 4010 transactions!

5010 Trading Partner Migration –

We would like to share our 5010 migration updates to the transactions and our revised time lines:

Transaction	Version Number	BCBSNC Migration Timeline
270/271 Eligibility Inquiry/Response	005010X279A1	July – December
276/277 Claim Status Inquiry/Response	005010X212	Sept – December
278 Authorization Request/Response	005010X217	July – December
837 Institutional Claim Submission	005010X223A2	Sept – December
837 Professional Claim Submission	005010X222A1	Sept – December
835 Electronic Remittance Advice	005010X221A1	July – December
999 Acknowledgement	005010X231	July through 2011

- CMS approved the HIPAA 5010 ERRATA (addenda) at the end of 2010 that defined new versions for the 270/271, 837I, 837P, and 835 transactions. For your convenience we have listed all the transactions and their versions. **Please confirm your Vendor/Trading Partner solutions have begun their 5010 migration with BCBSNC.** Remind them that if the wrong version of a transaction is sent, it will not be accepted.
- You may view the new BCBSNC 5010 Companion Guides and access the new ECR (Electronic Connectivity Request) on our Provider EDI website at <http://www.bcbsnc.com/content/providers/edi/hipaainfo/index.htm>. Please ensure your Trading Partner is aware of and following our defined process.

835 Remittance Direct Receivers –

If you are a Direct Receiver of an 835 Remittance, all of your NPI's must migrate from the 4010A1 to the 5010 version at the same time. Once you migrate to 5010, the 4010A1 will no longer be sent. Only one 835 version (4010A1 or 5010) can be active at any one time.

837 Claim Submission Changes –

There are some changes to the 5010 837 Claims transaction that you should review and discuss with your Vendor/Trading Partner:

NPI Related Changes:

- The Billing Provider (2010AA Loop) must be a Healthcare Provider. It can no longer be a Billing Service.
- The Billing Provider NPI must be sent at the lowest level of NPI for your organization. If you are a large medical group that has one overall group NPI for the entire entity, but different group NPIs for each clinic, the Billing Provider NPI (2010AA Loop NM109) should be the NPI for the submitting clinic, not the overall NPI for the entire entity.
- The Rendering Provider (2310B & 2420A loops) should not be sent on an 837 if the Rendering Provider is the same as the Billing Provider; otherwise your 5010 claims will be rejected. Ensure your vendor is aware and is prepared to send the individual's NPI or send no Rendering information if the NPI would be the same as the Billing Provider.

(continued on page 7)

Member ID Related Changes

Member IDs, when unique, should be submitted in the Subscriber Loops on all transactions. You should not send both the Subscriber and Patient IDs if they are unique. Here are examples of a Unique ID and single ID for entire family.

BlueCross BlueShield BlueOptions

Subscriber Name:	01	ABC123 COMPANY
Subscriber ID:		YPPW12345678
Members Health and Dental:		In-Network Member Responsibility:
Mary T. Schneider	02	Primary \$10
Donald T.	03	Specialist \$20
Health Only		Urgent Care \$30*
Kathleen A.	04	ER \$150*
Robert K.	05	Prescription Drug \$10/\$25/\$50/25%
Dental Only		*Same for out-of-network
Nathan M.	06	
Gabrielle L.	07	

Dental Blue PPO Rx

Combination of two parts together made ID unique.

BlueCross BlueShield Federal Employee Program Basic

Government-Wide Service Benefit Plan

I M SAMPLE
contract holder name

R30048539
identification number

112
enrollment code

effective date of coverage

(See Reverse Side)

AdvancePCS RX Bin # 610415 RX Group # 85006500

Single ID for whole family (112 indicates self/family)

BCBSNC is committed to working closely with our network of health care professionals to ensure a seamless transition. We will continue to keep you updated as more information becomes available.

The Effects of the ICD-10 Transition on Provider Practices

Providers completing HIPAA transactions must use ICD-10 diagnosis codes for services provided on or after **October 1, 2013**. To be prepared for this transition, you should begin planning now if you haven't done so already. Here are a few ways this transition will affect your practice:

- **More robust codes** – Codes will grow from 17,000 to 140,000. Remember that you only need to know the codes that relate directly to your area of specialty and/or those that you use most frequently. Code books and styles will completely change. Using these codes will require more detailed knowledge of medical terminology, anatomy and pathophysiology.
- **Updated policies and procedures** – You must change any office policy or procedure tied to a diagnosis code, disease management, or tracking.
- **Medical record documentation** – ICD-10 codes will better reflect the specificity already inherent in the patient's medical record. Physicians will continue to document the patient's plan of care to include laterality, stages of healing, trimester of pregnancy, episodes of care, etc. Other health care professionals will also need to continue to document patient information with specificity.

Determine where ICD-9 codes currently appear in your systems and business processes; budget for training, reprinting of Superbills, etc.; and, finally, develop an ICD-10 timeline. Don't forget to evaluate all vendor and payer contracts and upgrade as needed.

Health Care Reform

We continue to update our health care reform-related Web site, nchealthreform.com, to help North Carolinians better understand the impact of health care reform and what it means to them. Our site includes general information about health care reform, along with some specifics for our state's business community.

BCBSNC is taking an active role in explaining the impacts of health care reform and letting North Carolinians know

that we are committed to making the new federal law work for our state. Please share this Web site with our members if they are looking for information as health care reform is implemented.

You can also suggest other helpful online resources, such as:
The Kaiser Family Foundation's site at KFF.org
The federal health care reform site at healthcare.gov

Get paid faster – sign up today for electronic funds transfer

Participating providers can enroll for electronic funds transfer (EFT) via *Blue e* or online at <http://www.bcbsnc.com/content/providers/edi/hipaainfo/> agreements.htm. EFT is a much faster way of receiving payments than waiting for a check to arrive in the mail and then depositing it. Additionally, participating providers will receive copies of their EFT-voided checks electronically for more immediate access. Upon confirmation of your EFT enrollment (usually 1 business week), BCBSNC can make your payments electronically, to a bank

account of your direction. BCBSNC does not charge any fees for participation; however, providers should contact their financial institution to find out about any fees related to this service. Questions related to EFT should be directed to BCBSNC provider customer support at **1-919-765-2293**.

Please note that the Federal Employees Plan (FEP) do not provide EFT services. Claims paid for services delivered to FEP patients are paid by check only.

How are medical necessity decisions made?

We want to ensure that all physicians are aware of the criteria and guidelines utilized by BCBSNC to make medical necessity decisions for membership enrolled in our commercial products. In these decisions we are guided by the Milliman Care Guidelines and BCBSNC corporate medical policy.

Our licensed nurses use Milliman Care Guidelines to authorize coverage for inpatient services, home care and rehabilitation services. Milliman Care Guidelines are updated annually and practitioners can obtain a copy of a specific Milliman Care Guideline or a BCBSNC medical policy by calling our Healthcare Management & Operations department at **1-800-672-7897**, ext. **57078**. Our medical policies are also available through our Web site at bcbsnc.com via the "Provider" portal.

If a nurse cannot approve a service, a BCBSNC medical director (who is licensed in North Carolina) will review the case and may approve or deny coverage based on Milliman Care Guidelines or BCBSNC medical policy, along with clinical judgment. Only a medical director can deny coverage for a service based on medical necessity. We encourage you to take part in a "peer-to-peer" consultation regarding a case before or after a determination, because a discussion between physicians can help clarify a situation and affect the determination. A BCBSNC medical director is always available during regular business hours and can be reached by calling **1-800-672-7897**, ext. **51019**.

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Healthcare Management & Operations (HM&O)

The BCBSNC HM&O department works with physicians and members to facilitate the most medically appropriate and cost-effective, quality care for our members. Staff in the HM&O department is available to assist with arranging:

- Certification requests (except for mental health/substance abuse)
*Certification requests for members enrolled in the State Health Plan **1-800-672-7897**
- Prior review requests (except for mental health/substance abuse)
* Prior review requests for members enrolled in the State Health Plan **1-800-672-7897**
- Discharge planning (when calling include extension **51910** to be connected with discharge services)
*Discharge planning requests for members enrolled in the State Health Plan **1-800-672-7897** at extension **53065** (except for mental health/substance abuse)
- Pharmacy quantity limitations (when calling include extension **51689**)
- Transplants
- Medical director reviews (when calling include extension **51019**)
- Request a reconsideration of an initial medical necessity denial
- Physician hotline (when calling include extension **51019**)

BCBSNC HM&O department makes available fax capability for providers arranging member services and supplying BCBSNC requested documentation. Fax numbers are as follows:

NCHC (North Carolina Health Choice)	1-919-765-4890
NCHC-Retro	1-919-765-4891
Pharmacy	1-800-795-9403
Restricted Access / Step Therapy	1-888-348-7332
State PPO	1-866-225-5258
Discharge Services	1-800-228-0838
Commercial	1-800-459-1410
Commercial	1-800-571-7942
Commercial	1-800-672-6587

To learn more about HM&O services, processes or policies, please refer to the provider e-manual available at bcbsnc.com. HM&O is available 24 hours.

Support	Day	Hours
Representative	Monday – Thursday Friday	8 a.m. – 7 p.m. 8 a.m. – 5 p.m.
Voice Messaging System	Monday – Friday	Other than regular business hours

Peer to peer review

BCBSNC medical directors are available to discuss clinical problems and benefit issues with network providers particularly where there are issues that complicate the management of the patient's condition.

- A peer to peer review is a clinical discussion between a requesting physician and a BCBSNC medical director.
- If you have questions about a certification request, you may request to speak directly to a medical director by calling **1-800-672-7897, x51019**.
- A peer to peer review may also be requested by a BCBSNC medical director in order to obtain more clinical information from an attending physician before making a final determination.
- The purpose of the peer to peer discussion is to give the requesting physicians an opportunity to discuss the clinical details of a requested service.

Commercial Drug Formulary Update

BCBSNC and its Pharmacy & Therapeutics (P&T) Committee have reviewed the following drug products and made the following decisions regarding their formulary tier (copayment) placement on the BCBSNC commercial formulary.

Tier 2 – Preferred Brands (second-lowest co-payment amount)

Brand Name	Generic Name	Therapeutic Class
Lodosyn®	Carbidopa	Antiparkinsonism Agents
Colcrys®	Colchicine	Gout Therapy
ActoplusMet® XR	Pioglitazone/metformin	Non-Insulin Hypoglycemic Agents
Tirosint®	Levothyroxine	Thyroid Hormones
Prograf®	Tacrolimus	Immunosuppressant Drugs
Celebrex® ¹	Celecoxib	NSAIDs
Vimovo® ¹	Naproxen / esomeprazole	NSAIDs
Paxil® suspension	Paroxetine	Antidepressants
Suboxone® oral film	Buprenorphine / naloxone	Narcotic Antagonists
Pancreaze®	Lipase / protease / amylase	Digestive Enzymes

® Brand names are registered trademarks of their respective owners.

¹ Prior review may be required.

(continued on page 11)

Tier 3 – Brands (second-highest co-payment amount)

Brand Name	Generic Name	Therapeutic Class
Altace®	Ramipril	ACE Inhibitors
Bystolic®	Nebivolol	Beta Blockers
Coreg CR®	Carvedilol	Beta Blockers
Azor®	Amlodipine / Olmesartan	Antihypertensive Combinations
Tekturna®/HCT	Aliskiren / HCTZ	Antihypertensive Combinations
Tribenzor®	Amlodipine / olmesartan / HCTZ	Antihypertensive Combinations
Caduet®	Amlodipine / atorvastatin	Calcium Channel Blocker – Lipid/Cholesterol Lowering Agent
Covera-HS®	Verapamil	Calcium Channel Blockers
Advicor®	Niacin / lovastatin	Lipid/Cholesterol Lowering Agents
Altoprev®	Lovastatin ER	Lipid/Cholesterol Lowering Agents
Antara®	Fenofibrate	Lipid/Cholesterol Lowering Agents
Fenoglide®	Fenofibrate	Lipid/Cholesterol Lowering Agents
Lescol®/XL	Fluvastatin	Lipid/Cholesterol Lowering Agents
Lipofen®	Fenofibrate	Lipid/Cholesterol Lowering Agents
Lovaza®	Fenofibrate	Lipid/Cholesterol Lowering Agents
Triglide®	Fenofibrate	Lipid/Cholesterol Lowering Agents
Welchol®	Colesevelam	Lipid/Cholesterol Lowering Agents
Livalo®	Pitavastatin	Lipid/Cholesterol Lowering Agents
Fortamet®	Metformin ER	Lipid/Cholesterol Lowering Agents
Glumetza®	Metformin ER	Non-Insulin Hypoglycemic Agents
Glyset®	Miglitol	Non-Insulin Hypoglycemic Agents
Prandimet®	Repaglinide / metformin	Non-Insulin Hypoglycemic Agents
Prandin®	Repaglinide	Non-Insulin Hypoglycemic Agents
Symlin® / SymlinPen®	Pramlintide	Non-Insulin Hypoglycemic Agents
Loestrin® 24 Fe	Norethindrone acetate / ethinyl estradiol	Non-Insulin Hypoglycemic Agents
Ortho Evra®	Norelgestromin / ethinyl estradiol	Oral Contraceptives
Beyaz®	Drospirenone / ethinyl estradiol / levomefolate	Contraceptive patch
Natazia®	Dienogest / estradiol valerate	Oral Contraceptives
Proventil® HFA	Albuterol sulfate	Oral Contraceptives
Dulera®	Mometasone / formoterol	Beta Agonist Inhaler
Cambia®	Diclofenac potassium packet	Miscellaneous Pulmonary Agents
Alsuma® ^{1,2}	Sumatriptan succinate injection	Headache Therapy
Exalgo®	Hydromorphone ER	Headache Therapy

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1 Physician certification/prior review may be required.

2 Quantity limits may apply.

(continued on page 12)

Tier 3 – Brands (second-highest co-payment amount) (continued)

Brand Name	Generic Name	Therapeutic Class
Lysteda®	Tranexamic acid	Hemostatics
Mirapex®	Pramipexole	Antiparkinsonism Agents
NitroMist®	Nitroglycerin spray	Rapid-Acting Nitrates
Olepto®	Trazodone ER	Antidepressants
Pennsaid®	Diclofenac sodium topical	NSAIDs
Zyclara®	Imiquimod 3.75%	Miscellaneous Dermatologicals
Sorilux®	Calcipotriene foam	Antipsoriatic / Antiseborrheic
Jalyn®	Dutasteride / tamsulosin	BPH Therapy
Oravig®	Miconazole buccal tablet	Antifungal Agents
Silenor® ¹	Doxepin	Hypnotic Agents
Suprep®	Sodium, potassium & magnesium sulfates	Bowel Evacuants
Xerese®	Acyclovir / hydrocortisone	Topical Antivirals
Zirgan®	Ganciclovir	Ophthalmic Antivirals
Zymaxid®	Gatifloxacin	Ophthalmic Antibiotics
Zuplenz®	Ondansetron	Antivertigo & Antiemetic Agents
Zortress®	Everolimus	Immunosuppressant Drugs

® Brand names are registered trademarks of their respective owners.

1 Physician certification/prior review may be required.

2 Quantity limits may apply.

Tier 4 – Specialty Drugs (co-insurance amount)

Brand Name	Generic Name	Therapeutic Class
Cayston®	Aztreonam lysine	Miscellaneous Anti-Infectives

® Brand names are registered trademarks of their respective owners.

BCBSNC Offers Free Health Programs to Help Members Achieve their Care Goals

Our disease management program, Member Health PartnershipsSM (MHP), is available to most BCBSNC members and enrollment is completely voluntary. Members can visit bcbsnc.com for more information and to complete an online enrollment survey or they can call into **1-800-218-5295** and select **option 1** to enroll over the phone. MHP is an integrated program that supports your treatment plan and assists your patients to better understand their conditions and provides support by offering:

- Educational materials that discuss disease basics, medications, necessary tests, and the impact of lifestyle behaviors and co-morbidities on health

- Support through 1:1 telephonic health coaching that may offer insight into disease self-management, answer general health questions, support communication with the patient and physician, and more
- Free nutrition counseling visits with an in-network registered dietitian
- Tools that enhance patient-provider communication

We want you to be aware of what MHP offers, as your patients may bring some of these materials to an upcoming office visit. If you have questions about MHP, please e-mail those questions to partnerships@bcbsnc.com.

Clinical practice guidelines

Clinical practice guidelines help clarify care expectations and are developed based on evidence of successful practice protocols and treatment patterns. Some of these guidelines have recently been updated and are adopted and distributed as a reference tool to assist the practitioner community as they make decisions about clinically appropriate care for their patients. BCBSNC endorses clinical practice guidelines from nationally recognized organizations (e.g., American Heart Association). Clinical guidelines are available on the following conditions:

- Asthma
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Cholesterol Management
- Depression
- Heart Failure
- Hypertension
- Overweight and Obesity

All guidelines are rigorously reviewed by BCBSNC medical directors and BCBSNC's Physician Advisory Group (an external panel of physicians who provide guidance and oversight), in addition to BCBSNC's Quality Improvement Committee.

Conveniently located on the Provider page of our Web site bcbsnc.com, you can view these at anytime, day or night. Visit bcbsnc.com, click on Provider, and then click on Clinical Practice and Preventive Health Guidelines, or you may click on the following link, <http://www.bcbsnc.com/content/providers/guidelines.htm> to view the specific guidelines. If you would like to receive a written copy of any of the guidelines, please call **1-800-218-5295**. If you leave a message, please indicate which guideline(s) you are requesting and spell your name, practice name and give your mailing address. We will then mail the requested materials. Additionally, please leave a daytime telephone number where we can reach you in case we have any questions.

Network Management Consolidates to One Statewide Toll Free Number

In order to provide more streamlined provider service, Network Management has consolidated to one toll free number effective Monday, January 31, 2011. The toll free number to access your local Network Management Specialist is **1-800-777-1643**. Phone hours are from 9 AM to 4 PM ET.

Consolidating to one toll free number provides more direct access to the Network Management team and is more provider-focused. Individual county prompts have been removed which will reduce wait times. There is an option to hold or leave a message if a team member is not immediately available. Prompts take callers directly to other commonly used contacts such as ESolutions (for EDI services).

Never Events and Hospital Acquired Conditions (HACs)

Effective January 18, 2011, BCBSNC has updated the policy on Hospital Acquired Conditions and Never Events to provide more detailed explanation on the conditions and codes. To read the revised policy, please follow the link to the BCBSNC provider portal for the medical policy - http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/nonpayment_for_serious_adverse_events.pdf.

Please also see the below Questions & Answers, to help answer any questions you may have regarding this new policy.

Frequently Asked Questions

1. Why is BCBSNC making changes to the current corporate medical policy around Serious Adverse Events?
To better align BCBSNC policies and procedures with CMS guidelines and to meet BCBS Association mandates around uniform handling of claims.
2. When are these changes effective?
January 18, 2011
3. What are Never Events and Hospital Acquired Conditions (HACs)?
Never events are adverse events that are serious, largely preventable, and are of concern to both the provider and the public. Hospital Acquired Conditions (HACs) is an undesirable situation or condition arising during a time spent in a hospital or medical facility.
4. If a claim has a Never Event code, how will the claim process?
For dates of service on or after January 18, 2011, the entire claim will be denied for provider payment.
5. If a claim has a HAC code, how will the claim process?
For dates of service on or after January 18, 2011, the claim will be re-priced without the HAC code to determine appropriate level of payment on any covered and reimbursable charges.
6. Are these payment decisions appealable?
No
7. How were providers notified around these changes to the current corporate medical policy?
The new policy was announced on the BCBSNC provider portal for a 90 day review period. BCBSNC staff met with the North Carolina Hospital Association (NCHA) in the fall of 2010. Network Management Provider Relations staff have included this topic on monthly agendas with statewide facility providers.
8. Does this policy follow current Medicare guidelines and processes around Serious Adverse events?

BCBSNC has made every attempt to align our policies and procedures with current Medicare requirements when feasible.

(continued on page 14)

Hospital Acquired Conditions and Codes

Current ICD-9 Diagnosis Code list:

HAC	Complicating Condition (CC) Major Complicating Condition (MCC) (ICD-9-CM Codes)
Foreign object retained after surgery	998.4 (CC) 998.7 (CC)
Air embolism	999.1 (MCC)
Blood incompatibility	999.6 (CC)
Pressure ulcer stages III and IV	707.23 (MCC) 707.24 (MCC)
Fall and Trauma: <ul style="list-style-type: none"> • Fracture • Dislocation • Intracranial injury • Crushing injury • Burn • Electric shock 	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994
Catheter-associated urinary tract infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular catheter-associated infection Manifestations of poor glycemic control <ul style="list-style-type: none"> • Diabetes ketoacidosis • Nonketotic hyperosmolar coma • Hypoglycemic coma • Secondary diabetes with ketoacidosis • Secondary diabetes with hyperosmolarity 	999.31 (CC) 250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)	
Surgical site infection following certain orthopedic procedures <ul style="list-style-type: none"> • Spine • Neck • Shoulder • Elbow 	
Surgical site infection following bariatric surgery for obesity <ul style="list-style-type: none"> • Laparoscopic gastric bypass • Gastroenterostomy • Laparoscopic gastric restrictive surgery 	

(continued on page 15)

Hospital Acquired Conditions and Codes Current ICD-9 Diagnosis Code list: (continued)

HAC	Complicating Condition (CC) Major Complicating Condition (MCC) (ICD-9-CM Codes)
Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures <ul style="list-style-type: none"> • Total knee replacement • Hip replacement 	

Never Events	ICD-9-CM Codes
Performance of wrong operation on correct patient	E876.5
Performance of wrong operation on (procedure) intended for another patient	E876.6
Performance of correct operation (procedure) on wrong body part/site	E876.7

Inpatient Admission Precertification Reminder for Federal Employee Program (FEP) Members

Prior to admitting a Federal Employee into the hospital (*in a non-emergency situation), precertification must be obtained from the Service Benefit Plan.

To help members better understand their benefits and their potential costs and obligations to providers; please remind your Federal Employee-patients that precertification is required for all inpatient admissions. Based on the information provided, the request for an inpatient admission may be certified at an outpatient status by the plan rather than inpatient status which

would result in higher out-of-pocket costs for the member.

We also ask that providers help keep members informed of precertification status and the Service Benefit Plan's approval or denial of an inpatient stay, so that members may better prepare and understand their portion of hospital-care costs.

*In the event of an emergency admission the Service Benefit Plan must be notified within two business days following the day of the emergency admission.

Clarification for Billing Pediatric Immunization Administration CPT Codes 90460 and 90461

BCBSNC would like to provide clarification for our network of healthcare providers billing the new immunization Current Procedural Terminology (CPT) codes 90460 and 90461. CPT codes 90460 and 90461 became effective January 1, 2011.

Clarification for appropriate filing of CPT codes 90460 and 90641 is not due to any change in BCBSNC processes. The instructions are being offered to facilitate

payment and reduce claim denials as duplicates, healthcare professionals submitting claims to BCBSNC for immunization administration using codes 90460 and 90461 for multiple vaccines and/or multiple components, must report the code(s) in units and not per line item. By submitting per line item, claims are unable to be adjudicated appropriately. Please see the following page for additional clarification:

(continued on page 16)

Clarification for Billing Pediatric Immunization Administration CPT Codes 90460 and 90461 (continued)

Definition

90460 - Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

90461 (add on code) - Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (list separately in addition to code for primary procedure)

Billing Requirements

CPT codes 90460 and 90461 require each component of a vaccine to be reported separately. CPT defines a component as all antigens in a vaccine that prevents disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple vaccine components.

- Use code 90460 to report the first (or only) vaccine/toxoid component of each vaccine.
- Use code 90461 to report each additional component of that particular vaccine.

Codes 90460 or 90461 should not be listed on a claim more than once. Repeated administration code(s) will deny as duplicate services.

Example

An 18 year patient is counseled on risks and benefits of Pneumococcal Vaccine, Diphtheria- Tetanus- Pertussis- Hepatitis B, Poliovirus Vaccine and seasonal influenza. The healthcare provider administers each vaccine, completes chart documentation and vaccine registry entries, and verifies there is no immediate adverse reaction.

Vaccine Code	Descriptor	Number of Components	Administration Code
90670	Pneumococcal Conjugate Vaccine	1	90460 x1
90723	Diphtheria, Tetanus Toxoids, Acellular Pertussis, Hepatitis B, Poliovirus Vaccine	5	90460 x1 90461 x4
90658	Influenza Virus Vaccine	1	90460 x1

DO NOT repeat codes 90460 and 90461 on separate lines with the units split among those lines - three lines of 90460, four lines of 90461. Remember, when codes 90460 and 90461 are repeated on separate lines, line items will deny as duplicates!

DO list multiple units for each code to receive proper reimbursement. Multiple units for each code should reflect:

- 90460 x 3 units – The 3 units represent the only component for pneumococcal and influenza vaccine and first component for DtaP-HepB-IPV
- 90461 x 4 units - The 4 units represent each additional component of DtaP-HepB-IPV; no other vaccine has more than one component to report.

Provider Transparency – Cost and Quality Tool

Beginning July 31, 2011, BCBSNC will provide transparency on costs, quality, and out-of-pocket expenses to members via the secure BCBSNC My Member Services website portal. This tool will enhance our member's capabilities to make educated decisions regarding costs and treatment options available with their provider community.

The Provider Transparency Cost and Quality Project will be delivered in three phases:

- + Phase 1 (July 31, 2011) will utilize treatment category cost data from BCBSA's National Consumer Cost Tool (NCCT) to provide estimated costs for certain common, high-volume elective services
- + Phase 2 (later this year) will involve displaying a member's estimated out-of-pocket expenses for the above services
- + Phase 3 (later this year) will involve displaying quality information for imaging facilities based on accreditations achieved by the national accrediting bodies

Data displayed to members will include:

- + Phase 1 - Costs
 - Plan to display national and local costs for the 59 treatment categories currently available in the NCCT
 - 40+ additional treatment categories to be added in Fall 2011
 - The estimates come exclusively from health insurance claims. Treatment costs reflect total cost estimates for the most common elective services at network hospitals, ambulatory surgery centers, imaging centers and doctors' offices across the country.
- + Phase 2 - Out of pocket expenses
 - Plan to display estimated out-of-pocket expenses using member's "real-time" deductible and co-insurance data
- + Phase 3 - Quality
 - Plan to display quality information for 11 radiology treatment categories
 - Quality data based on accreditations achieved by the following accrediting bodies:
 - American College of Radiology
 - Intersocietal Accreditation Commission
 - Joint Commission on Accreditation of Healthcare Organizations

If you have any additional questions, please feel free to contact your dedicated Network Management Provider Relations team member.

Reminder: 24-Hour Response Time for Urgent Authorization Requests

Beginning January 3, 2011, if you are making an URGENT authorization request on a WEEKEND or HOLIDAY, for a service or services requiring prior authorization, please fax or phone the request to the following.

Fax: **1-800-571-7942**
 Phone: **1-800-672-7897**

As part of the implementation of the Health Care Reform guidelines, BCBSNC will respond to all urgent authorization requests within 24-hours of receipt of the authorization request and supporting clinical documentation - including on weekends and holidays.

(continued on page 18)

Reminder: 24-Hour Response Time for Urgent Authorization Requests (continued)

Providers should only be submitting urgent authorization requests on cases that meet the criteria of urgent as outlined below. Because of the new guidelines it is important to remove the word “urgent” from all fax coversheets and documentation, unless the case is truly considered urgent; this will prevent a delay in the review process.

For Federal Program Employees, please refer to the provider manual for instructions regarding submission of requests for services that require prior authorization.

As part of the new Health Care Reform Guidelines **urgent requests** are defined as requests for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function; or, in the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

October 1, 2011 Prior Authorization, Restricted Access, and Quantity Limitation Updates

Effective October 1, 2011 additional utilization management requirements go into effect for the following diagnostic categories:

Prior Review: Peginterferon Alfa, Hepatitis C prescription medications, and other miscellaneous prescription medications

Quantity Limitations and Prior Review Changes for Self-Injectables and Pristiq

Details about these programs and the changes taking place can be found at <http://www.bcbsnc.com/content/services/formulary/rxnotes.htm>.

2010 QI Program Evaluation Summary

BlueCross and BlueShield of North Carolina (BCBSNC) conducts an annual evaluation of its Quality Improvement Programs to: review effectiveness, assess goal achievement, evaluate the deployment of resources, trend clinical and service indicators, assess outcomes of quality improvement initiatives in quality of care and service, document and trend input from advisory groups and other stakeholders, and identify opportunities for improvement in the ongoing provision of safe high-quality care and service to members. This report summarizes the evaluation findings of BCBSNC data from January 1, 2010 through December 31, 2010.

Notable Findings

Overall, the QI Program met or exceeded 90% of the 251 goals outlined. The BCBSNC PPO Rating of Health Plan is in the **50th ranking percentile**.

QI program improvements were demonstrated in the following preventive care services: Breast Cancer Screenings, Childhood Immunizations, Colon Cancer Screenings, and the Flu Shot Campaign. Improvement was also identified with mental health hospitalization follow-ups, as well as comprehensive diabetes eye care and cholesterol screenings. Member access and service goals were exceeded, especially in the areas of Enrollment and Claims Operational Performance. The Bridges to Excellence for ASO performance program concluded in 2010 with increased NCQA recognitions in North Carolina. In addition to these successes, improvement in member satisfaction was achieved with our Asthma, Specialty Care, CAD, and Child Healthy Weight Member Health Partnership modules. The 2010 Plan results indicate that member satisfaction could be improved in areas of our Health Line Blue Nurse Line, Getting Care Quickly and Getting Needed Care, Diabetes, Pregnancy, Migraine, CHF, Tobacco Free, Adult Healthy Weight, High Cholesterol and Hypertension, and Stress Member Health Partnership modules.

(continued on page 19)

2010 QI Program Evaluation Summary (continued)

Highlights & Accomplishments

1. **Breast Cancer Screenings:**

The 2010 BCBSNC rate for this measure was 72.05%, which was above goal, and greater than 4 percentage points above both regional (67.63%) and national (67.05%) averages.

2. **Childhood Immunizations:**

The HEDIS rate for childhood immunizations improved from a baseline of 20.18% in 2008 to 45.55% in 2010. The 2010 rate is also above the regional average (42.38%) and BCBSNC ranks second in the five PPO plans in NC for this measure.

3. **Colon Cancer Screenings:**

The BCBSNC rate for this measure improved from a baseline of 47.69% in 2009 to 50.26% in 2010, which is 2 percentage points above goal, and above both the regional (50.14%) and national (47.03%) averages.

4. **Flu Shot Campaign:**

The 2010 PPO flu vaccine rates among members 50 and over was at 51.78%, which is three percentage points higher than 2009. BCBSNC was also above the regional (50.59%) and national (50.46%) averages.

5. **Mental Health Hospitalization Follow-Ups:**

In 2010 BCBSNC tracked two mental health hospitalization follow-up measures: 7 days (45.54%) and 30 days (68.59%). Both measures exceeded their baseline goals by nine percentage points.

6. **Comprehensive Diabetic Eye Care:**

In 2010, BCBSNC scored 44.53% for comprehensive eye exams, which is an increase of nine percentage points over the 2009 score. The 2010 rate is also higher than the Regional (41.33%) and National (42.60%) averages. Additionally, the Plan's rate for the HbA1c was 85.64% in 2010, which was a seven percentage point increase over 2009.

7. **Customer Service Enrollment and Claims Operational Performance:**

Year-end cumulative performance for each CGO operational performance measure exceeded goals. Additionally, the 2010 CAHPS results show BCBSNC ranks first in the five PPO plans in NC for this measure for accuracy of PPO claims handling.

8. **Bridges to Excellence for ASO Programs:**

In 2010, BCBSNC rewarded physicians for 459 recognitions with a total of \$118,895 in rewards payments. While reward payments were not as significant for physicians because only a small number of ASO groups participated (approximately two), it is expected that the plan gained similar results to the BTE pilot. The results include: fewer specialist and ER visits, lower high cost radiology, and lower average length of stay.

9. **Blue Quality Physician Program:**

Achieving Blue Quality Physician Program recognition requires considerable effort on the part of the practice. The first practice received recognition in February of 2011. By the end of December, 29 practices with 140 physicians were recognized in the BQPP program. The Quality Based Network staff continues to promote the program among the eligible practices in the state.

10. **Provider Performance Analytics:**

The MedVantage Health Smart Designer software was installed and the Provider Performance Analytic reports were run comparing primary care and cardiology against their peers on 22 nationally recognized quality measures that focus on preventive care, cardiac services, heart failure and diabetes. Reports will be distributed to physicians in early 2011.

11. **Blue Distinction Centers:**

Two new Blue Distinction Center programs, Spine Surgery (10 facilities) and Knee and Hip Replacement (16 facilities) were implemented in January of 2010. In addition, BCBSNC participated as a pilot plan researching the concept of a "System of Care" for common cancer care with the Blue Cross Blue Shield Association and seven hospitals. This new view of Blue Distinction Centers is needed because various types of providers, locations, and services are often involved in the treatment of cancer patients. Further work on this concept is expected in 2011.

BCBSNC Member Rights and Responsibilities

We feel that it is important for you to be aware of the member rights and responsibilities that we share with our members each year. The following information outlines our expectations regarding how our members should interact not only with us, their health insurer, but also with you, their provider of health care services, and in turn, how we should interact with them.

As a BCBSNC member, you have the right to:

- Receive information about your coverage and your rights and responsibilities as a member.
- Receive, upon request, facts about your plan, including a list of doctors and health care services covered.
- Receive polite service and respect from BCBSNC.
- Receive polite service and respect from the doctors who are part of the BCBSNC networks.
- Receive the reasons why BCBSNC denied a request for benefits for treatment or health care service, and the rules used to reach those results.
- Receive, upon request, details on the rules used by BCBSNC to decide whether a procedure, treatment, site, equipment, drug or device needs prior approval.
- Receive, upon request, a copy of BCBSNC's list of covered prescription drugs. You can also request updates about when a drug may become covered.
- Receive clear and correct facts to help you make your own health care choices.
- Play an active part in your health care and discuss treatment options with your doctor without regard to cost or benefit coverage.
- Participate with practitioners in making decisions about your health care.
- Candid discussions about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.
- Expect that BCBSNC will take measures to keep your health information private and protect your health care records.
- Voice complaints and expect a fair and quick appeals process for addressing any concerns you may have with BCBSNC.
- Make recommendations regarding BCBSNC's member rights and responsibilities policies.
- Receive information about BCBSNC, its services, its practitioners and providers and members' rights and responsibilities.
- Be treated with respect and recognition of your dignity and right to privacy.

As a BCBSNC member, you should:

- Present your BCBSNC ID card each time you receive a service.
- Read your BCBSNC benefit booklet and all other BCBSNC member materials.
- Call BCBSNC when you have a question or if the material given to you by BCBSNC is not clear.
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, advise your doctor.
- Provide BCBSNC and your doctors with complete information about your illness, accident or health care issues, which may be needed in order to provide care.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Make appointments for non-emergency medical care and keep your appointments. If it is necessary to cancel an appointment, give the doctor's office at least 24-hours notice.
- Play an active part in your health care.
- Be polite to network doctors, their staff and BCBSNC staff.
- Tell your place of work and BCBSNC if you have any other group coverage.
- Tell your place of work about new children under your care or other family changes as soon as you can.
- Protect your BCBSNC ID card from improper use.
- Comply with the rules outlined in your member benefit guide.

Specialty Pharmacy Program Changes Effective July 1, 2011

BCBSNC has created a new specialty pharmacy network for the medical and pharmacy benefit effective July 1, 2011 for commercial business (Medicare Part D is not impacted). This network will consist of providers that meet rigorous criteria, including:

- Available nursing or pharmacist services 24 hours a day, 7 days a week, 365 days a year;
- Disease specific initial and ongoing evaluations, monitoring of medication adherence, counseling, and documented interventions; and
- Specialty pharmacy quality accreditation (URAC) or accreditation in process.

As a reminder, specialty medications can at times be received through a member's MEDICAL and/or PHARMACY benefits. The following grid shows the network options available to underwritten (UW) versus Administrative Services Only (ASO) groups under the different benefits:

	UW	ASO	
		100 – 249 Members	250+ Members
Medical	New Specialty Pharmacy Network	New Specialty Pharmacy Network	New Specialty Pharmacy Network
Pharmacy	New Specialty Pharmacy Network	New Specialty Pharmacy Network	Current Medco Network OR
	Network	Network	Preferred ASO Pharmacy (CuraScript)

As of 7/1/11, all MEDICAL specialty pharmacy benefits will be through the newly contracted providers. NOTE: this change does NOT affect physician practices that bill specialty pharmacy medications directly to BCBSNC (i.e.: buy and bill). Current Contracted Specialty Pharmacies under the new Specialty Pharmacy Network:

Ascend Specialty Rx	BioPlus Specialty Pharmacy	Commcare Pharmacy
CoramRx	CuraScript	CVS Caremark
Drugco Health	Kerr Health	Long's Drug
MedPro Rx	US Bioservices	

The PHARMACY benefits as of 7/1/11 will be through this same network, except that ASO 250+ groups will have an option: they can either stay with the Medco pharmacy network that exists today, or they can select the preferred specialty pharmacy provider - CuraScript.

CuraScript Specialty Pharmacy has contracted with BCBSNC to become part of its new Specialty Pharmacy Provider Network. In addition, CuraScript will be the exclusive specialty pharmacy for certain self-funded employer group health benefit plans (ASO groups) administered by BCBSNC. This network change is effective July 1, 2011.

It is important for all providers rendering pharmacy benefits via the BCBSNC Specialty Pharmacy Network to verify benefits prior to rendering services; some ASO groups may have not have selected CuraScript as their Specialty Pharmacy provider or provide pharmacy coverage to its members.

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>. You can also submit questions and request for information to Specialty.Pharmacy@bcbsnc.com.

Clear Claim Connection and Correct Coding Initiative Edits

BCBSNC is increasing its compliance with industry standards by adopting the Center for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) into our payment policy.

BCBSNC will be enhancing our current claims edits in Clear Claim Connection (C3) and will be including CCI bundling edit logic in all future versions of C3 effective 10/1/2011.

The Centers for Medicare and Medicaid Services (CMS) developed correct coding combination edits based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

CCI edits are pairs of Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for

the same beneficiary on the same date of service.

The CCI edits being added to Claim Check review will be the same CCI edits applied to both commercial business claims and Medicare Advantage (MA) claims during the claim check bundling review process. CCI edits are currently applied to MA claims during the claim bundling process. Many CCI edits also currently are being applied to BCBSNC commercial business. This change enhances the completeness of that editing process, by incorporating all CCI edits into the bundling review. However, claims for commercial business and MA business may not bundle alike, as both BCBSNC commercial business and MA business may apply additional bundling edits outside of those found in Claim Check.

Reminder: Please reference the corporate medical policy titled Code Bundling Rules Not Addressed in Claim Check for BCBSNC commercial business claims bundling guidelines and other bundling editing processes that are not addressed in C3 system.

REMINDER: BCBSNC Policy on Third-Party or Servicing Provider Ordering of Diagnostic Services

BCBSNC's Diagnostic Imaging Management (DIM) Program was initiated in February 2007 to encourage the use of appropriate diagnostic imaging services at the appropriate time and in the appropriate order. Communication to BCBSNC's provider network has included language indicating that the ordering provider must contact American Imaging Management (AIM) to request authorization for the DIM service and that the servicing provider cannot request the authorization. There are two exceptions to this policy:

1. If the ordering provider (PCP, specialist) has diagnostic imaging equipment in his/her office and will be filing the claim for the technical component (or billing globally) for the DIM service;
- or**
2. The servicing provider is an interventional radiologist, as established by BCBSNC's Credentialing Department.

The reasoning behind this policy is that only the ordering, or referring, provider will have sufficient clinical data on the patient to provide to AIM for a medical necessity determination. Servicing providers such as hospitals or freestanding radiology practices are not likely to have seen the patient and are therefore not the most appropriate source of clinical data such as patient medical history, symptoms and/or diagnoses.

As such, it is a violation of BCBSNC's policies for:

1. A servicing location to market or offer to BCBSNC referring providers its services in obtaining the authorization from AIM on behalf of the referring provider; or
2. A referring provider to allow the servicing location to contact AIM on their behalf to request the authorization for DIM services.

This policy is referenced in Section 8.9 of the BCBSNC Provider eManual and is therefore incorporated by reference into BCBSNC's provider agreements. See <https://www.bcbsnc.com/assets/providers/public/pdfs/BlueBook-July2010.pdf> for details.

Drug Wastage Policy Effective September 1, 2011 – Billing BCBSNC for Discarded Drugs and Biologicals and Filing with the JW Modifier

BCBSNC encourages providers to care for and administer drugs or biologicals to patients in a clinically appropriate and efficient manner. BCBSNC acknowledges there are circumstances where unused drugs or biologicals must be discarded. In which case, BCBSNC will pay for both the administered and discarded drug and biological if specific criteria are met including tracking of the wastage.

Billing BCBSNC for Discarded Drugs and Biologicals

As noted above, BCBSNC will provide payment for discarded drugs or biologicals when certain criteria are met. Specifically, BCBSNC will reimburse discarded drugs or biologicals up to the dosage amount indicated on the vial or package label minus the administered dose(s) if:

- The drug or biological is supplied in a single-use vial or single-use package;
- The drug or biological is initially administered to the patient to appropriately address the patient’s condition and any unused portion is discarded. A provider cannot bill BCBSNC for discarded drugs if none of the drug was initially administered to a patient (e.g. BCBSNC beneficiary misses an appointment).
- The amount wasted is recorded in the patient chart or a separate waste report log;
- The provider’s written policy and practice is to manage single-use drugs and biologicals and bill all payers in the same manner; and
- The amount billed to BCBSNC as discarded drug is not administered to another patient.

Modifier JW

Modifier JW is defined as “drug or biological amount discarded/not administered to any patient.” Physicians, hospitals and other providers or suppliers may use modifier JW to indicate drug wastage for non-inpatient administered drugs.

BCBSNC requests providers report the drug amount administered on one line, and on a separate line report the amount of drug NOT administered (wasted) with modifier -JW appended to the associated HCPCS code.

It should be noted that modifier JW is not used when the actual dose of the drug or biological administered is less than the billing unit defined in the Healthcare Common Procedure Coding System (HCPCS) descriptor. For example, HCPCS J2175 descriptor states meperidine hydrochloride, per 100 mg. Therefore, one billing unit is equal to 100 mg. If 97 mg of J2175 is administered and 3 mg of J2175 is wasted, modifier JW should not be reported. This is because the amount administered, 97 mg, is less than the billing unit, which is 100 mg.

Billing Reminders for Drug Wastage

The following table summarizes the do’s and don’ts regarding billing for drug wastage.

Do’s	Don’ts
Do bill BCBSNC for discarded drugs and biologicals up to the amount on the single-use vial or package label minus the administered dose(s) when appropriate.	Do not bill BCBSNC the extra amount the drug manufacturer provided to account for wastage in syringe hubs. Many manufacturers provide an extra drug in each vial to account for the wastage in the syringe hubs. This extra amount should not be billed to BCBSNC because it is not an expense to the provider and it exceeds the amount on the vial or package label.

(continued on page 24)

Billing Reminders for Drug Wastage (continued)

Do's	Don'ts
Do use modifier JW when single-use vials or single use packages are appropriately discarded after administering a dose(s). The use of modifier JW is appropriate for services rendered in all non-inpatient places of service.	Do not bill BCBSNC for drug wastage if none of the drug was initially administered. BCBSNC will not reimburse for unused drugs or biologicals that result from a missed patient appointment.
	Do not bill BCBSNC for discarded drugs or biologicals for multi-use vials.

2011 Annual Provider Conference

BCBSNC invited Network Providers to participate in Provider Conferences held at four statewide locations throughout the months of July and August 2011. The theme of this year's conferences was *Mastering the Basics to Prepare for the Future-Addressing cost*

drivers together to help make health care in our State more affordable. You may access the conference presentations on the BCBSNC Provider Portal at <http://www.bcbsnc.com/content/providers/important-news/aug12-2011.htm>.

Who's Responsible for Rising Medical Costs?



When it comes to rising medical costs, everyone's got an idea about who's to blame — but we'd rather start talking about solutions than spend time looking for scapegoats.

That's why BCBSNC has launched [LetsTalkCost.com](http://www.letstalkcost.com): a place for facts and fruitful discussion. And, eventually, answers. From all of us.

Please visit the website at <http://www.letstalkcost.com/> and join in the discussion.

Every goat has a story to tell...

New iPhone and Android App Provides BCBSNC Customers Relevant Health and Cost-Saving Information



BCBSNC has launched HealthNAV^{SM1}, a new mobile application designed to help on-the-go customers' access information and manage their personal health care. The free app is now available for download by customers with an Apple® iPhone®, iPad™ and iPod touch®, and Android smartphones.

The version of the mobile app features four functions, including:

- An urgent care finder that helps customers locate in-network urgent care centers, as a more efficient and affordable alternative to emergency rooms.
- A prescription drug finder that allows customers to compare average drug costs, and find cheaper alternatives while they are discussing options with their doctor, or in preparation for a visit.
- Customer service access that provides customers one-click access to call a customer service representative when they need answers quickly.
- Health notes that let users store notes about personal and family health in one place, and includes suggested questions to ask your doctor during a visit.

To download the app, simply visit the iTunes® store or Android Marketplace, search for BCBSNC and click download. You also can learn more about the app by visiting www.bcbsnc.com/mobile.

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