The Provider NEWSLETTER

PARTNERS
National Health Plans of North Carolina, Inc.

www.partnershealth.com

Transition for PARTNERS Members Moving to BCBSNC Coverage

In the last newsletter we published several transition tips to aid in a smooth transition for members transferring to BCBSNC coverage. Those helpful hints focused primarily on Continuity of Care for medical services. To review the information, please refer to your copy of the October 2002 Newsletter or you can access previous newsletters via PARTNERS website at www.partnershealth.com (Provider section).

We would also like to remind providers of the importance of verifying insurance coverage each time services are provided due to the possibility of a change in coverage. Being alert to insurance changes allows you, the provider, to meet prior authorization requirements, if any, for the new plan. In some circumstances the requirements may be different and/or prior authorization may not be required . Verifying coverage and effective dates also assists your offices by eliminating possible delays associated with claims submission to an incorrect carrier.

Medical Necessity Review Guidelines To Change February 2003

Effective February 1, 2003 PARTNERS Medical Services Department will apply Milliman & Robertson (M&R) Care Guidelines for the following medical necessity reviews:

1. Inpatient and Surgical Care
2. Case Management: Recovery Facility Care
3. Care Management: Home Care

The guidelines are intended to assist in determining levels of care for most patients in most situations. All cases that do not meet the guidelines are referred to a PARTNERS Medical Director for review and determination of medical necessity. A denial of any services based on medical necessity can only be issued by a medical director after considering the individual circumstances of a particular member.

Similar to the guidelines PARTNERS currently uses for reviews (InterQual and Solucient Length of Stay), M&R are nationally recognized guidelines commonly used by hospitals, health plans and insurers across the country.

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Coding to the Highest Level of Specificity

ICD-9-CM is composed of codes with three, four, or five digits. Some three-digit codes stand alone. Other three-digit codes are further subdivided by the addition of fourth or fifth digits, which provide greater "specificity." Therefore, code as follows:

Use three-digit codes only if there are no four- or five- digit codes within that code category.

Use four-digit codes only if there are no five-digit codes for that category.

Use five-digit codes when they exist in a code category.

Sometimes fourth and fifth digits are not available. In these cases, do not add fourth and fifth digits to valid three-digit codes (i.e., do not add zeros to valid three-digit codes).

Truncated Codes

"Truncated" diagnosis coding means that the diagnoses are not coded at their highest level of specificity. PARTNERS does not accept truncated diagnosis codes. Assigned claims for physician services with truncated diagnosis codes will be returned - "EXEC: DENY: DO NOT BILL MEMBER NEED COMPLETE ICD-9 CODE." Examples of truncated diagnosis codes include:

(Diabetes Mellitus) 250 requires 5 digits. The fourth digit must be 0 through 9; the fifth digit must be 0 through 3.

(Osteoarthrosis and allied disorders) 715 requires 5 digits. The fourth digit must be 0, 1, 2, 3, 8, or 9; the fifth digit must be 0 through 9.

REMINDER - PARTNERS Claims Addresses

Hospital Claims:

PARTNERS
P.O. Box 17368
Winston-Salem, Nc 27116-7368

Professional Claims, Referrals, EOBs:

PARTNERS
P.O. Box 17268
Winston-Salem, NC 27116-7268

The Pharmacy Connection
Changes for 2003

Additions to the PARTNERS formulary effective October 2002:

- Concerta
- Microgestin FE
- Orfadin
- Lotronex (requires prior approval)

PARTNERS Prior Approval requirements removed for the following drugs, effective January 1, 2003:

- Adderall
- Avita
- Clomid/Serophene
- Depo-Provera 400mg
- Dexedrine
- Dextrostat
- Peg-Intron
- Rebetron
- progesterone supp.
- Retin-A
- Wellbutrin
- Zyvox

Deletions to the PARTNERS formulary effective January 1, 2003:

- Estrostep/Fe
- Loestrin/Fe
- Low-Ogestrel
- Ogestrel
- Zovia

Editorial

This newsletter, unless otherwise stated, applies to both Commercial and Medicare Choice members.

PARTNERS is committed to offering its health plans on a non-discriminatory basis.

PARTNERS does not discriminate based on color, religion, national origin, age, race, disability, handicap, gender, or health status as defined by CMS.

PARTNERS National Health Plans of North Carolina, Inc.

Provider Services
336-774-5400 or
1-888-296-9790

The Medicare Appeals Process versus Contracted Provider Payment Review

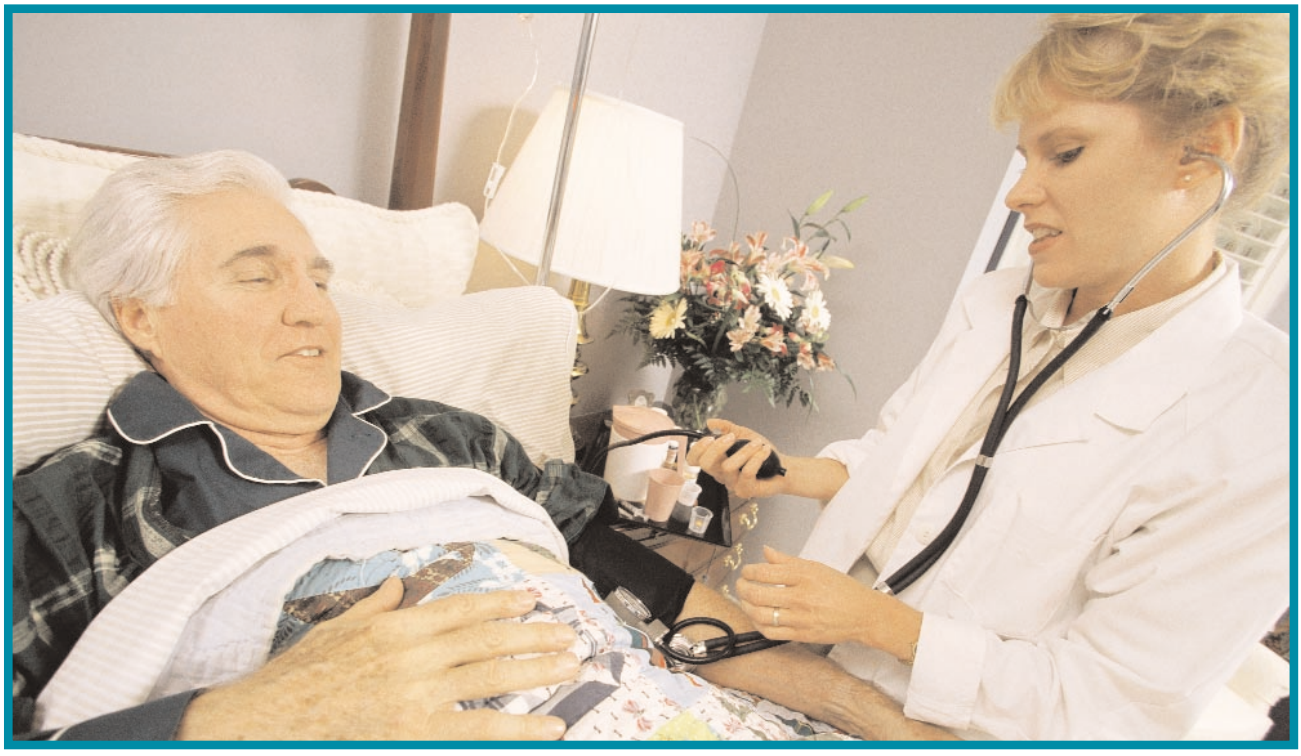
If you have received a service or claim denial on a PARTNERS Medicare Choice member and you believe the denial was erroneous, your request for review of the denial should be addressed to ***Medicare Provider Payment Review*** P.O. Box 17268, Winston-Salem, North Carolina 27116-7268.

There is a specific process that PARTNERS must use regarding Medicare+Choice service determinations and appeals. Keep the following points in mind before you send a request for review to Medicare Appeals:

- Generally, a contracted provider **cannot** file an appeal under the Medicare Appeals Process although they may dispute PARTNERS payment determination, holding the member harmless, by submitting documentation as instructed above.
- The member has a right to file an appeal under the Medicare Appeals process **only if** the member is liable for payment or if authorization for coverage of services has been denied. (In general, a member is not held liable for payment for services when the provider did not follow plan guidelines). When a member chooses to exercise their right to appeal, supporting documentation from their provider is helpful to insure a complete review of all information available
- If the member is liable for payment and the member authorizes the provider to seek reimbursement on their behalf, then a contracted provider can file an appeal under the Medicare Appeals Process on behalf of the member.

If you believe a claim determination on a PARTNERS Medicare Choice member was made erroneously, please remember to address your request for review to Medicare Provider Payment Review.

Please note one exception: *any provider can request or support an expedited service determination or expedited appeal review of a denied service authorization on behalf of a member.*



PARTNERS MEDICARE CHOICE
Comparison of Benefit Changes 2002-2003

PARTNERS will make changes to the individual benefit package as outlined below beginning January 1. Changes to group packages will vary.

2002	2003
Cost $40	**Cost** $45.
Out-of-Pocket Maximum None	**Out-of-Pocket Maximum** There is a $2500 maximum out-of-pocket limit for certain services Copayments are included *(with the exception of those for Rx and other rider benefits)*
Inpatient Hospital Care $250 Copay per admission for unlimited days.	**Inpatient Hospital Care** • Member pays $150 each day for up to 10 days per calendar year with no copayment thereafter. • There is a **$1500** maximum out of pocket limit every yr. This limit is combined with inpatient mental health services. • Unlimited days available each benefit period.
Inpatient Mental Health Care $250 Copay per admission but there is a 190-day lifetime limit in a psychiatric hospital.	**Inpatient Mental Health Care** • Member pays $150 each day for up to 10 days per calendar year with no copayment thereafter. • There is a **$1500** maximum out of pocket limit every yr. This limit is combined with inpatient hospital services. • Covered for up to 150 days per benefit period. There is a 190-day lifetime limit in a psychiatric hospital.
Skilled Nursing • Covered at a 100% • Covered for 100 days each benefit period.	**Skilled Nursing** • Member pays $75 each day for up to 10 days per calendar year with no copayment thereafter. • There is a **$750** maximum out of pocket limit every yr. • Covered for up to 100 days each benefit period.
Outpatient Surgery Covered at 100% per visit.	**Outpatient Surgery** $100 copay per visit in an ambulatory surgical facility.
Ambulance Service $25 copay per trip.	**Ambulance Service** $50 copay per ride.
Emergency Care $25 copay per visit (waived if admitted within 24 hours for the same condition).	**Emergency Care** $50 copay per visit (waived if admitted on an inpatient basis within 24 hours for the same condition).