The Provider NEWSLETTER

PARTNERS
National Health Plans of North Carolina, Inc.

www.partnershealth.com

HMO/POS

PARTNERS Medical Coverage Policies Updated

The following Medical Coverage Policy has been reviewed and approved by the Utilization Review/ Quality Improvement Physician Advisory Committee. Please Contact your Provider Relations representative for additional information. This policy applies to Medicare + Choice Members only. A separate policy was approved in April 2002 for Commercial Members.

TREATMENTS FOR OBSTRUCTIVE SLEEP APNEA AND BREATHING RELATED SLEEP DISORDERS

The Plan supports a stepwise approach to the treatment of obstructive sleep apnea, from the basic to the more complex. Sleep hygiene measures include weight loss where appropriate, avoidance of alcohol, sedatives, and caffeine in the pre-bedtime hours, allowing an adequate sleep time, and (where appropriate) alteration of the sleep position to reduce or eliminate position-specific events. Treatment is based on the member's particular clinical picture and on a recent polysomnogram performed under supervision in a credentialed sleep lab.

CPAP and BIPAP Requests require precertification by the Health Plan and documentation of a recent polysomnogram and CPAP/BIPAP titration in the sleep lab showing effectiveness at a documented pressure. In addition, the patient and either the sleep medicine physician or the vendor must be willing to undertake a good faith effort at CPAP/BIPAP compliance.

The Plan expects that the CPAP vendor and the prescribing sleep medicine physician will undertake appropriate measures to maximize the chance of success of the CPAP/BIPAP effort. These measures to acclimate members to therapy include emotional support to overcome initial reluctance where appropriate, alternate mask fitting for effect and comfort, nasal pillows, humidification, ramping, etc. and must be documented in the medical record. *Acclimation efforts are expected for a minimum of two months and must be supported by proper documentation and compliance chip information before these modalities will be considered failed.*

CPAP and BIPAP are considered Durable Medical Equipment (DME) and are eligible for coverage under the DME section of the member's Certificate of Coverage (C.O.C.). BIPAP is utilized when a trial with CPAP is unsuccessful or not tolerated or in other special circumstances. The initial rental period is for one month but may be extended where effectiveness or tolerance is in doubt. Purchase of the unit may be approved when the physician has evaluated the member after the initial trial

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period, has verified its effectiveness, and compliance information indicates a minimum average nightly use of six hours as indicated by the compliance chip.

Surgical Treatments for Obstructive Sleep Apnea and Upper Airway Resistance Syndrome are eligible for coverage when medically necessary. Precertification by the Health Plan and Medical Director review is required for all surgical procedures for sleep apnea. Hard copy documentation of the member's sleep history, physical examination, polysomnogram and all prior treatment is required for Medical Director review. Failure of a good faith effort at conservative therapy will normally be required before a surgical request is approved.

Benefit payments are subject to the contractual obligations of the plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Certificate of Coverage (C.O.C.), the C.O.C. always governs the determination of benefits.

Interactive Voice Response System to be Discontinued

In recent months, PARTNERS has evaluated the different mechanisms by which providers make contact with our company. As a result, the Interactive Voice Response (IVR) system will be discontinued, effective October 15, 2002. Nevertheless, there are two alternatives by which you can contact PARTNERS.

HealthTrioconnect, an Internet-based service, enables you to verify member eligibility and also inquire about claim status. Because it is web enabled, HealthTrioconnect provides information at the click of a button – which means that you can quickly obtain the most current member information. To become a registered user, simply go to the provider registration page at www.healthtrioconnect.com, follow the prompts, and complete security agreements for each user at your practice or facility. Fax completed forms to the attention of Scott Edwards at 336-659-2974.

You may also contact PARTNERS, via the Provider Information Line, at 1-888-296-9790. Representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday.

PARTNERS is committed to making the transition from IVR as smooth as possible. If you have questions regarding options for contacting us, please contact your Network Management Coordinator or the Provider Information Line.

Important Information Regarding Change of Address

PARTNERS has moved!

Effective
Monday, July 22, 2002
PARTNERS
physical address changed to:

5635 Hanes Mill Road,
Winston-Salem, NC 27105

**** Note: ALL P.O. BOXES FOR CLAIMS SUBMISSION REMAIN UNCHANGED ****

Physician Claims/Referrals:

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

Hospital Claims:

P.O. Box 17368
Winston-Salem, NC 27116-7368

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

Statement Regarding Utilization Management Decisions

PARTNERS National Health Plans of North Carolina, Inc., and it's 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. PARTNERS does not compensate or provide any other incentives to any practitioner or other individual conducting utilization management review to encourage denials. The Health 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, service or underutilization of services.

PARTNERS Home Care Program for Members Undergoing Total Joint Replacement

PARTNERS recently advised participating orthopedic surgeons of the availability of a home care program for the post-operative care of their patients undergoing hip and knee replacement surgery. We are pleased to announce an expansion of the availability of these home care services. The Plan has evaluated the joint replacement home care programs of two additional contracted vendors whose programs consist of a pre-operative home assessment visit to evaluate a member's suitability for a home program, patient education, rehabilitation, and nursing services, based on the physician's protocol. We are happy to engage any contracted vendor you desire for the care of your joint replacement patient. Our staff will inquire as to your preference at the time the procedure is authorized.

Should you have questions or comments regarding the home care program, please call the Provider line at 1-888-296-9790.

The Pharmacy Connection
September 2002

Additions to the PARTNERS formulary effective January 2002:

- Arixtra
- Biaxin XL
- Neulasta
- Rebif

Addition to the PARTNERS formulary which requires Prior Approval.

- Bextra (please call Express- Scripts at 1-800-417-8164 for authorization of this drug)

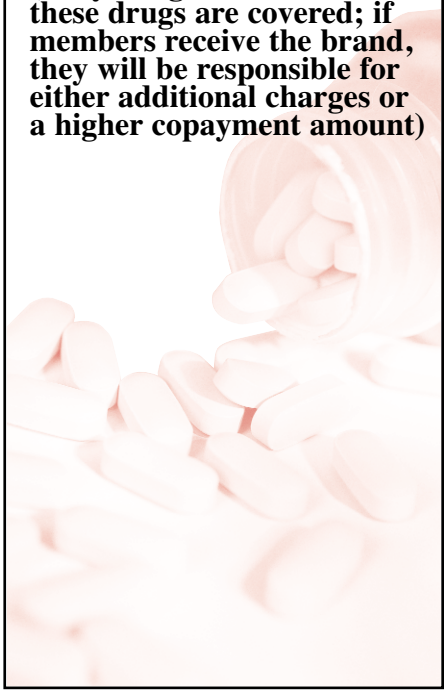
Quantity Level Limits Addition:

- Bextra (10mg is limited to 34 tablets and Bextra 20mg is limited to 68 tablets).

MAC'd drugs

- Actigall
- Adalat CC
- Adderall
- Aygestin
- Cleocin/T
- Cytoxan
- Dolophine
- Erycette
- Eskalith
- Eulexin
- K-Dur
- Lotrisone
- Neoral
- Retin-A
- Rifadin
- Rocaltrol
- Rythmol
- Stadol NS
- Tapazole
- Tegretol/XR
- Vaseretic
- Zestril
- Zestoretic.

(Only the generic version of these drugs are covered; if members receive the brand, they will be responsible for either additional charges or a higher copayment amount)



Transition For PARTNERS Members Moving To Blue Cross And Blue Shield Of North Carolina!

Blue Cross and Blue Shield of North Carolina (BCBSNC) would like to assist PARTNERS members in the transition to BCBSNC coverage. We understand the concern for quality health care during this period and we would like to make this a smooth transition. Below are some helpful transition tips to assist these members during this time.

Continuity of Care for Medical Services

In some cases, PARTNERS members will not find their provider included within BCBSNC's network of participating providers. To assist in this transition, BCBSNC is offering a Continuity of Care process to allow qualifying members to continue to see a non-participating provider for a certain period of time. For a member to be eligible for Continuity of Care, treatment must be ongoing and one of the following conditions must apply:

1. **Member has an acute illness,** a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
2. **Member has a chronic illness or condition, a disease or condition** that is life-threatening, degenerative or disabling and requires medical care or treatment over a prolonged period of time.
3. **Member is terminally ill**, a medical prognosis that the individual's life expectancy is six months or less.
4. **Member is in the second or third trimester of pregnancy or completing postpartum care.**

BCBSNC must authorize services provided by non-participating providers in advance for them to receive in-network benefits for care under the Continuity of Care process.

We will be asking PARTNERS members to confirm whether or not their doctor is in the BCBSNC network. The member may contact BCBSNC's Customer Service Department listed on the back of their ID card, to obtain a Continuity of Care request form. Authorization for Continuity of Care must be requested within 45 days after the effective date of coverage with BCBSNC.

Durable Medical Equipment (DME)

Effective July 1, 2002, the dollar limit requiring prior approval for purchase of DME increased from greater than $300 to greater than $600. The increased dollar amount applies to covered items billed with a valid HCPCS code and with a current fee schedule. Prior approval is required for purchase of items greater than $600 and for rental or continued rental DME.

Effective August 1, 2002, Medical Services no longer sends out letters to confirm rental item authorizations or purchases. The authorization information will continue to be communicated to the requesting provider telephonically or via facsimile at the time the service is authorized. A letter was sent to contracted DME and prosthetic vendors regarding the discontinuation of the written communication.

If you have any questions regarding an authorization or have a request for an authorization for DME, please call the Medical Services Department at 1-800-942-5695.

Medicare+Choice Service Determinations And Timeframes

A service determination is any decision, (authorizations, referrals, denials and discontinuations) that PARTNERS or a provider makes regarding coverage of healthcare services under the M+C contract between PARTNERS and CMS (formerly HCFA) and the enrollee's certificate of coverage. Enrollees under a M+C product are entitled to have decisions about the receipt of services made within timeframes established and monitored by CMS.

PARTNERS or providers must have two procedures in place to respond to service requests. A standard procedure is required for making determinations as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receiving the request. An expedited procedure is required for making determinations as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

The information below will help you know what options are available to you as a provider requesting payment authorization from PARTNERS (or expected of you when you are responding to requests for referrals from enrollees).

Q-1 Who Can Request a Service Determination?

A-1 1) An enrollee (or his/her authorized representative), 2) Any provider involved in the enrollee's care

Q-2 What if more time is needed to make the determination?

A-2 An extension of up to an additional 14 calendar days is permissible in some cases when the delay is in the enrollee's best interest. This can be used when more time is needed to obtain records from outside sources to make the decision.

Q-3 How long does PARTNERS take to make standard determinations?

A-3 In general, PARTNERS makes determinations well within the CMS 14-day mandated standard. Typically, PARTNERS determinations are made within 2 to 4 days for prospective or pre-service requests.

Q-4 When a situation is urgent and the standard timeframe is not appropriate, what options does a provider or enrollee have?

A-4 In situations where applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, a provider or enrollee can request (orally or in writing) an expedited determination. Expedited determinations are made as expeditiously as the enrollee's health requires, but no later than 72 hours from the date of the request.

For requests made by an enrollee, without physician support, PARTNERS will determine if the situation qualifies for the expedited timeframe process. If the situation does not qualify for an expedited review, a standard review will be provided.

For requests made or supported by a physician, PARTNERS will expedite the request if the physician

indicates that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. If the physician does not believe that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, then PARTNERS and the physician will determine, based on the enrollee's condition, a response date no later than the maximum 14 days available under the standard process.

Q-5 How is a provider notified of the decision?

A-5 Typically, notice is given to a provider at the time of the call to PARTNERS, or via a return telephone call. Enrollees are given written notice of all denied standard determinations and of all approved and denied expedited determinations made by PARTNERS.

Q-6 Who should a provider contact regarding a service determination?

A-6 Providers should continue to direct all service determinations to the PARTNERS Medical Services department as they have in the past.

Q-7 As a provider of services, what should I be prepared to tell enrollees about determinations?

A-7 At each patient encounter with an M+C enrollee, a practitioner must notify the enrollee of his or her right to receive a detailed written notice from PARTNERS regarding enrollee services, upon request. This means that providers must be prepared to direct enrollees back to PARTNERS if they have questions about denied services or referrals. If the denial is made by the provider, PARTNERS will obtain the specifics about the denial, and submit that information to the enrollee in a format acceptable to CMS. PARTNERS will provide more information on this topic in upcoming newsletters and in the provider manual as additional guidance is obtained from CMS.

Practice Guideline Updates

Several updates to PARTNERS Preventive Health Practice Guidelines are attached. **Please update your Provider Manual accordingly**. If you have questions, or need to request a complete Provider Manual, please contact the Provider Information Line at 1-888-296-9790. The following guideline updates are attached:

1.2.10 Guidelines for Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults
1.2.12 Guidelines for the Management of Adults with Diabetes Mellitus
1.2.13 Guidelines for the Management of Children and Adolescents with Type I Diabetes Mellitus
1.2.15 Otolaryngology Follow-Up Post Tympanostomy Tube Insertion
1.2.20 Management of Gastroesophageal Reflux
1.2.21 Management of Dyspepsia
1.2.22 Screening for Urine Protein – Diabetes

An updated version of the Quick Reference Guide is also attached; please replace the page in your Provider Manual (located on the third page at the beginning of the Manual) with the updated version.