Have You Applied for Your National Provider Identifier Yet?

The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) require a national standard identifier for health care providers. That standard identifier – the National Provider Identifier (NPI) – is scheduled to be in place by May 2007 for all providers submitting health care transactions electronically.

The NPI is a 10-digit number that will replace all current Blue Cross and Blue Shield of North Carolina (BCBSNC) provider numbers on all electronic transactions. Providers who utilize electronic transactions are required under the HIPAA regulations to request a NPI, notify their payers of their NPI assignment, and use their NPI on all electronic transactions.

How to Apply for Your NPI

The Centers for Medicare and Medicaid (CMS) has contracted with Fox Systems to be the enumerator responsible for administering the assignment of the NPI(s) to providers. Providers may apply via a Web site or by submitting a paper application. Fox Systems began accepting online applications for NPI(s) on May 23, 2005, and began accepting paper applications on July 1, 2005.

Providers should not begin using their NPI on transactions until BCBSNC has issued specific instructions regarding the submission of the NPI. The new provider identifier must be used on all standard electronic transactions with health plans no later than May 23, 2007.

The following sources can provide you with updates and information about the NPI project, along with instructions on how to apply for your NPI:

- The CMS NPI online resource at: http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/default.asp
- The HIPAA Hotline at 1-866-282-0659
- Send an e-mail to AskHIPAA@cms.hhs.gov

BCBSNC is actively assessing its processes and systems that will be impacted by the NPI requirements and anticipates sharing its finalized plan with you later this year. We encourage you to prepare by reviewing your respective processes and systems, and by contacting your clearinghouses and vendors to determine their plans for NPI implementation.

You may want to ask your practice management vendor or clearinghouse the following questions:

- Are you aware of NPI?
- Have you started internal discussions about how your company will implement the NPI requirements?
- Do you plan to build a crosswalk from the current provider ID numbers to the NPI numbers prior to May 2007?

(Continued on page 2)
BCBSNC Participating Labs

 Participating network physicians have contractually agreed that when the need arises for a BCBSNC patient to receive other professional services – such as reference laboratory services – they will refer our members to other participating network providers. To confirm that a lab is participating, please refer to this list or contact BCBSNC Customer Services for the most up-to-date information. The following list of contracted reference laboratories are participating in all BCBSNC products as of July 1, 2005:

- Alfigen, Inc.
- Ameripath Consulting Pathology Services
- Carolina Imaging and Diagnostics, LLC
- Carolina Medical Lab Group, Inc.
- Carolinas Medical Center Lab
- Clinical Data, Inc.
- Clinical Laboratory Services
- Coastal Carolina Pathology, PA
- Dianon Systems
- Dominion Diagnostics, LLC
- Michael Friedberg, M.D.
- Fullerton Genetics Center
- Gene Care
- Genzyme Genetics
- Greensboro Pathology Associates, PA
- H P R H Reference Lab
- Harris Histology Relief Service
- Lab Corp. of America
- Liposcience, Inc.
- Macon County Health Department Lab
- Meridian Laboratory Corporation
- Mission St. Joseph’s Reference Lab
- Nextrave Diagnostic Laboratories
- Pathologists Medical Lab
- Piedmont Pathology Associates
- Presbyterian Laboratory Services
- Quest FKA SBCL
- Rex Laboratory Outreach
- Sciteck Clinical Laboratories, Inc.
- Select Diagnostics, Inc.
- Skin Pathology Associates, PC
- Spectrum Laboratory Network
- Spruce Pine Reference Lab
- Triad Clinical Laboratory
- US Labs
- Wilkesboro Clinical Lab

If you are currently using the services of a nonparticipating reference laboratory, please encourage them to contact BCBSNC for more information about becoming a contracting provider in our networks. Reference labs that would like to participate in our networks can complete an application, which can be downloaded at bcbsnc.com.

Have You Applied for Your National Provider Identifier Yet? (continued from page 1)

- Where will you obtain/accept provider’s NPI(s)? (examples: from provider, CMS, other)
- When do you plan to accept only NPI(s) from providers?
- Do you expect providers to use both their existing provider number and their NPI until May 2007?
- Do you understand the HIPAA NPI rule as it relates to electronic transactions and the mandated implementation scheduled for May 23, 2007?
- Does your current practice management software support a 10-digit identification number? If not, when can I expect this functionality to be delivered? What will it cost me?
- Does your practice management system have the capability to provide both the payer-specific ID and NPI during the transition or will it require a one-time cutover to NPI?
Extreme Makeover for BCBSNC Web Site

When was the last time you visited the “I’m a Provider” section of the BCBSNC Web site? We’ve received an extreme makeover and invite you to take a virtual tour of the new and improved online resources available to the provider community. The site still contains all the resources and informative extras that you’ve come to expect; only now they’re available with a fresh new look, added information, and a much more user-friendly ease of maneuverability. Please come visit us at bcbsnc.com and select “I’m a Provider.” While you’re there, be sure to click on “Important News” for the latest in provider news updates.

Ambulatory Surgical Center Update

Please be aware that The Centers for Medicare and Medicaid Services (CMS) recently updated the ambulatory surgical center (ASC) Healthcare Common Procedure Coding System (HCPCS) codes list to reflect the Medicare-approved ASC procedures that were added to or deleted from the ASC list effective July 1, 2005. As part of BCBSNC’s HIPAA compliance measures, we accept only active codes. Please convert to the new codes by their effective dates in order to prevent claim mailbacks.

NC Health Insurance Institute

BCBSNC will be participating in the upcoming North Carolina Hospital Association’s, NC Health Insurance Institute. This year’s event will be held on November 10 and 11 at the Sheraton Imperial Hotel in Durham.

New Provider Manual for Ancillary Providers

New editions of the BCBSNC Your 2005 Provider Manual for Ancillary Providers were mailed to all participating ancillary providers in July. Ancillary providers are categorized as: home health, hospice, home infusion, durable medical equipment, private duty nursing, skilled nursing facilities and dialysis facilities. If you are an ancillary provider and have not yet received your copy of the Your 2005 Provider Manual for Ancillary Providers, please contact your local BCBSNC Network Management representative.

Duke Energy Corporation Prefixes

BCBSNC members employed by Duke Energy Corporation are identified by three alpha prefixes on their member ID cards:

- DKN – Classic Blue® Membership
- DEE – Blue OptionsSM Membership
- DUK – Blue Options Membership

Please remember to request a copy of the member’s most current ID card at each visit. Wausau Benefits formerly provided health plan administration for Duke Energy members with the alpha prefixes of DKN and DEE. Some Duke Energy retirees may have the DUK prefix. Please be sure that claims for 2005 services are sent to Blue Cross and Blue Shield of North Carolina as listed on the member’s ID card.

Change in HMO and PPO Benefits for Imaging Services

BCBSNC HMO and PPO members’ diagnostic benefits were redesigned for high-cost imaging procedures, including CTs, MRIs, MRAs, and PET scans performed in the office. Prior to April 1, 2005, benefits for these diagnostic services were eligible for 100 percent benefit consideration if provided in a physician’s office or freestanding radiology facility. After April 1, 2005, benefits for HMO and PPO members now include applicable deductible and coinsurance for CTs, MRIs, MRAs, and PET scans regardless of the location (office, freestanding radiology, outpatient or inpatient) of the service.

Miscellaneous DME Codes

Earlier this year, durable medical equipment (DME) providers were notified that miscellaneous codes were to be submitted with a manufacturer’s invoice. This applies to all miscellaneous DME claims submitted with dates of service on or after April 1, 2005. Some of the codes are E1399, B9998, K0108, L2999, and L3999, but this is by no means an exhaustive list. Again, a manufacturer’s invoice is required for ANY miscellaneous code that is billed. If you have questions, please contact your BCBSNC Network Management representative.
Protecting Your Patients’ Health Care Needs

Did you know that there are standards in place that protect your patients? The National Committee for Quality Assurance (NCQA), a not-for-profit organization that accredits Blue Cross and Blue Shield of North Carolina (BCBSNC), has developed standards that do just that. BCBSNC wants you to know that:

- Any decisions made about coverage for care or services are based on your patient’s benefit plan, BCBSNC medical policy, and information from the doctor about the patient’s medical condition.
- The BCBSNC doctors and nurses that review your and your patients’ requests for service or coverage are not rewarded for denying coverage.
- The BCBSNC doctors and nurses that review your and your patients’ requests for service or coverage are not given bonuses or other financial incentives to deny or limit care.

At BCBSNC, we are committed to making appropriate coverage decisions about health care that meet the terms of your patients’ health benefit plan, while meeting their medical needs.

How Are Medical Necessity Determinations Made?

At BCBSNC, we feel that it’s important for you to know how medical necessity decisions are made and what criteria we use to make those decisions on a case-by-case basis. Licensed nurses and physicians using established criteria make all medical necessity determinations. BCBSNC criteria includes Milliman Care Guidelines and BCBSNC Corporate Medical Policy.

The Milliman Care Guidelines are used by our nurses to authorize coverage for inpatient services and for length-of-stay extensions. They also use the Milliman Care Guidelines for home care and rehabilitation services. BCBSNC Corporate Medical Policy applies more to services on our prior Plan approval list. Practitioners can obtain a copy of the Milliman Care Guidelines or a specific BCBSNC Medical Policy by calling our Medical Resource Management Department at 1-800-672-7897, ext. 57078. Medical Policies are also available online at bcbsnc.com.

If a nurse cannot approve a particular service, a BCBSNC medical director reviews 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 advantage of the offer of a “peer-to-peer” consultation regarding a case before or after a determination, because a discussion between physicians can help to clarify a situation and may affect the determination. A BCBSNC medical director is available for consultation during regular business hours and can be reached at 1-800-672-7897, ext. 51019.

Take Part In Our Provider Satisfaction Survey

What if by voicing your opinion, you could win a $50 American Express gift certificate, and at the same time help in the effort to improve the health of all North Carolinians through physical activity? Well, by taking a few minutes to complete our annual provider satisfaction survey, you can do just that.

Congratulations are already due to Elizabeth Hooks with Ferncreek General Surgery, PA of Fayetteville, and Melanie Moore with Pisgah Physical Therapy & Sports Rehab, Inc., who took part in the 2005 BCBSNC provider satisfaction survey and each won a $50 American Express gift cheque.

In addition to each receiving a gift cheque, Elizabeth and Melanie helped sponsor Be Active North Carolina by participating in the survey. For each completed survey response received, Blue Cross and Blue Shield of North Carolina will donate $1 to Be Active North Carolina, a statewide initiative to increase the physical activity levels of all North Carolinians.

There’s still time for you to voice, help and win. Just go to bcbsnc.com and select “I’m a Provider,” then click on “Provider Survey.” Or, you can visit “What’s New” on Blue eSM and connect to the survey.

To learn more about Be Active North Carolina and their efforts in your community, visit them online at beactivenc.org.
Changes to Credentialing Process for Urgent Care Providers and Facilities

Blue Cross and Blue Shield of North Carolina (BCBSNC) wants you to know about upcoming changes to the credentialing process for urgent care facilities and providers. These requirements went into effect as of July 1, 2005, for new urgent care providers. Providers who are seeking re-credentialing will need to meet all requirements on their next scheduled re-credentialing cycle on or after July 1, 2006. The changes to the credentialing process are:

- Urgent care providers will need to sign the Provider Attestation of Urgent Care Competencies signifying that they possess the skills, knowledge and experience to recognize, manage and triage urgent/emergent conditions in adults and pediatric patients that include a specific list as outlined by BCBSNC.
- The provider will meet all requirements as outlined in the Provider Requirements for Urgent Care Setting document. These requirements are developed based on provider specialty.
- As a pre-requisite for inclusion in the BCBSNC urgent care facility provider database, the owner of the urgent care facility will sign the Attestation of the Urgent Care Facility.

Provider letters and all necessary forms were mailed to all providers of record for urgent care services. If you have any questions regarding this change in criteria or about any of the information you received, please contact your local BCBSNC Network Management representative.

CDC Expands Meningococcal Vaccine Recommendation

In February 2005, the Centers for Disease Control and Prevention (CDC) expanded its meningococcal vaccine recommendation to include adolescents entering middle school (11-12 years old) and high school (15 years old). This recommendation will increase the demand for this vaccine. Most BCBSNC benefit plans cover this vaccine when administered by a participating provider.

Unfortunately, many physicians do not carry this vaccine in their offices. In the past, this was because there was not a high demand for this vaccine. However, the changes in meningitis vaccine recommendations will obviously increase demand. Please consider carrying and administering this vaccine in your offices.

Also, there are now two meningitis vaccines on the market – the original polysaccharide vaccine and a new conjugate vaccine. Both vaccines can prevent four types of meningococcal disease including two of the three types that are most common in the U.S. While both vaccines are effective and protect about 90 percent of vaccinated patients, the conjugate vaccine is expected to give better, longer-lasting protection\(^1\). BCBSNC does provide reimbursement for both types of meningococcal vaccine, and we recently increased our reimbursement for the polysaccharide vaccine.

Again, please consider carrying and administering this important vaccine in your practice for the convenience of your patients.


Discount Available on Noncovered Self-Management Devices

All Blue Cross and Blue Shield of North Carolina members can receive a 40 percent discount on selected blood pressure monitors, heart-rate monitors, scales, breast pumps and breast pump supplies through Edgepark Surgical\(^1\), the leader in nationwide home delivery of medical supplies. For product and pricing (includes shipping) information or to place an order, have your patients call 1-800-321-0591 to speak with one of Edgpark Surgical’s friendly and knowledgeable customer services representatives. Patients that mention that they are BCBSNC members will be transferred to a dedicated customer service representative.

\(^1\)BlueLINK
Drug Prior Approval and Quantity Limitation Now Includes Blue Advantage

Effective January 1, 2006, we will expand our prior approval (PA) and quantity limitation (QL) programs for prescription drugs to include Blue Advantage®, which is our health benefit plan for self-insured individuals. These programs already apply to Blue Care® and Blue OptionsSM members.

The quantity limitation program is a concurrent drug utilization program that encourages the appropriate use and dosage of a prescribed drug based upon the U.S. Food and Drug Administration’s approval and supporting medical literature. Drugs currently subject to quantity limits include Triptans (e.g., Amerge and Imitrex) and Migranal nasal spray, Stadol, Toradol, Proton Pump Inhibitors and Hypnotics.

Prior approval is a program that applies to specific drugs that are prescribed for a narrow list of conditions. The PA program requires that BCBSNC obtain the diagnosis and certain necessary clinical information before the drug is approved for payment. Drugs that currently require prior approval include growth hormones, botulinum toxins, certain antifungals, COX-2 inhibitors, Antipsoriatrics and DMARDs.

Requests for prior approval for any of the above prescription drugs or requests for quantity limit considerations that exceed the dosage limits should be directed to our Medical Resource Management Department at 1-800-672-7897. You can also refer to our Web site at bcbsnc.com for the most up-to-date information regarding drugs that are subject to both the prior approval and quantity limitation programs.

Four-Tier Formulary Available This Fall

Due to the high cost of specialty pharmaceuticals, coupled with demands from employer groups for increased cost-sharing by members, Blue Cross and Blue Shield of North Carolina will introduce a four-tier formulary benefit effective at group renewals on or after October 1, 2005. This will be an optional benefit for the October 2005 benefit changes; however, it will be mandatory for 2006 benefit changes.

Currently, the majority of BCBSNC members have a three-tier formulary benefit with a flat copayment for generic, preferred and nonpreferred drugs. Typical member liability for the four-tier benefit is a 25 percent coinsurance with a $100 out-of-pocket maximum for a 30-day supply. This change will be reflected on the member’s BCBSNC ID card (for example: $10/$20/$30/25%).

For most medications, the current formulary tier placement will not change. The fourth tier will include certain drugs that are commonly classified as “specialty medications.” These drugs are high-cost therapies. Cost-effective alternatives may be available at a lower tier. If appropriate, please consider alternative therapies in a lower formulary tier as patients’ out-of-pocket expenses will be significantly higher for drugs in the fourth tier.

For your convenience, the most current list of drugs in the fourth tier will be posted online at bcbsnc.com. You may also find the searchable formulary helpful as well. Our formulary is updated on a quarterly basis, after careful review by the Pharmacy & Therapeutics Committee, which is a group of practicing physicians and pharmacists in North Carolina.

Exclusion of Selected Self-Injectables from Medical Benefits

Effective October 1, 2005, or upon the patient’s subsequent group renewal, Blue Cross and Blue Shield of North Carolina will no longer cover select self-injectables under the medical benefit.

Currently, self-injectable drugs are paid if they are administered in a provider’s office or through the prescription drug benefit. With the October 1, 2005, change, these specified self-injectables will no longer be covered when they are administered in the provider's office. Members will need to purchase their self-injectable drug at the pharmacy. In situations where members need training on how to administer the drug in question, the member can purchase the drug at the pharmacy and then take it to the physician’s office for training. Providers may bill for the administration of the injection in these situations.

The list of self-injectables that will be excluded from coverage under the medical benefit is subject to change. To view the most current list of self-injectables, please visit our Web site at bcbsnc.com on or after October 1, 2005.

New Generics Added to Tier 1

The following drug products have recently become available generically. They are now available on Tier 1 of the BCBSNC prescription drug formulary, which is the lowest drug copayment level for BCBSNC members.

Please remember to tell your patients that the U.S. Food and Drug Administration requires that generic drugs to have the same quality, strength, purity and stability as their brand-name drug counterparts. Help your patients save money – prescribe generic drug products for them when appropriate.
Rx Corner

New Generics - Tier 1 (Lowest Copayment)

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dantrium capsules</td>
<td>Dantrolene sodium capsules</td>
<td>Muscle Relaxants &amp; Antispasmodic Agents</td>
</tr>
<tr>
<td>Sporanox capsules*</td>
<td>Itraconazole capsules*</td>
<td>Antifungal Agents</td>
</tr>
<tr>
<td>Duragesic patch</td>
<td>Fentanyl patch</td>
<td>Narcotics</td>
</tr>
<tr>
<td>DDAVP</td>
<td>Desmopressin acetate nasal solution, tablets</td>
<td>Miscellaneous Agents</td>
</tr>
<tr>
<td>Agrylin</td>
<td>Anagrelide</td>
<td>Miscellaneous Agents</td>
</tr>
<tr>
<td>Ultracet</td>
<td>Tramadol/acetaminophen</td>
<td>Miscellaneous Analgesics</td>
</tr>
<tr>
<td>Biaxin tablets</td>
<td>Clarithromycin tablets</td>
<td>Macrolides</td>
</tr>
</tbody>
</table>

*Prior approval (PA) required.

BCBSNC Drug Formulary Updates

Blue Cross and Blue Shield of North Carolina and its Pharmacy & Therapeutics Committee have reviewed the following new drug products and made the following decisions regarding their formulary tier (copayment) placement.

Tier 2 – Preferred Brand-Name Drugs (Second Lowest Copayment)

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campral</td>
<td>Acamprosate</td>
<td>Miscellaneous Agents</td>
</tr>
<tr>
<td>Fosrenol</td>
<td>Lanthanum carbonate</td>
<td>Miscellaneous Agents</td>
</tr>
<tr>
<td>Flovent HFA</td>
<td>Fluticasone CFC-free inhaler</td>
<td>Inhaled Corticosteroids</td>
</tr>
</tbody>
</table>

Tier 3 – Nonpreferred Brand-Name Drugs (Highest Copayment)

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lunesta</td>
<td>Eszopiclone</td>
<td>Hypnotic Agents</td>
</tr>
<tr>
<td>Equetro</td>
<td>Carbamazepine extended-release</td>
<td>Miscellaneous Psychotherapeutic Agents</td>
</tr>
<tr>
<td>VESIcare</td>
<td>Solifenacin</td>
<td>Anticholinergics &amp; Antispasmodics</td>
</tr>
<tr>
<td>Enablex</td>
<td>Darifenacin</td>
<td>Anticholinergics &amp; Antispasmodics</td>
</tr>
<tr>
<td>Luveris*</td>
<td>Lutropin alfa</td>
<td>Ovulatory Stimulants</td>
</tr>
<tr>
<td>Ventavis*</td>
<td>Iloprost inhaled solution</td>
<td>Miscellaneous Pulmonary Agents</td>
</tr>
<tr>
<td>Tracleer</td>
<td>Bosantan</td>
<td>Miscellaneous Pulmonary Agents</td>
</tr>
<tr>
<td>Parcopa</td>
<td>Carbidopa/levodopa</td>
<td>Antiparkinsonism Agents</td>
</tr>
<tr>
<td>Librax (reformulation)</td>
<td>Chlordiazepoxide/methscopolamine</td>
<td>Combination Anticholinergics</td>
</tr>
<tr>
<td>Evoclin</td>
<td>Clindamycin topical foam</td>
<td>Therapy for Acne</td>
</tr>
<tr>
<td>Clindesse</td>
<td>Clindamycin vaginal cream (single dose)</td>
<td>Vaginal Anti-Infectives</td>
</tr>
<tr>
<td>Clarinex-D 24 hr</td>
<td>Desloratadine/pseudoephedrine</td>
<td>Decongestant/Antihistamines</td>
</tr>
<tr>
<td>Combunox</td>
<td>Oxycodone/ibuprofen</td>
<td>Combination Narcotic/Analgesics</td>
</tr>
<tr>
<td>Biaxin XL</td>
<td>Clarithromycin extended-release</td>
<td>Macrolides</td>
</tr>
</tbody>
</table>

*Will be included in Tier 4 when this tier becomes effective on October 1, 2005.

Prior Plan Approval (PPA) List

Requirements for HMO, POS, PPO, and CMM*

General

- Applicable Lines of Business: Blue Advantage®, Blue Care®, Blue Choice®, Blue Options®, Classic Blue®

*For more information, visit the BlueCross BlueShield of North Carolina website at BlueCrossBlueShield.com.
Non-Social Security-Based ID Numbers
The State Health Plan (SHP) has completed the conversion to the non-Social Security-based ID numbers. All State Health Plan and NC Health Choice members were issued new ID cards by July 1, 2005. The new numbers consist of the lead alpha character “W” followed by 10 numeric digits. We will continue to accept claims, for an indeterminate time, submitted with the old Social Security-based ID number to avoid disruption of claims processing. However, please make every effort to update your records accordingly and submit claims with the new member ID numbers.

30-Day Grace Period for Wellness
Recently, the SHP made a change concerning the way we process wellness claims. The system has been programmed to allow a 30-day grace period. This means that a wellness claim will not deny if the service was rendered within the 30-day grace period before the required interval was outlived. The wellness benefits and the limitations concerning the patient’s age or intervals have not changed. The maximum allowance for wellness benefits per fiscal year is $150.

Remember the Basics For Prior Approval
When requesting prior approval, including the appropriate clinical documentation and some basic information with your request will allow for a quicker and more efficient response. Here is some key information to remember when requesting prior approval:

- Spell the member’s name correctly
- Include the member’s ID number
- Give the name of the provider ordering the service and the name of the provider who will provide the service (BCBSNC provider IDs are helpful, but not required)
- Include the patient’s diagnosis (ICD-9)
- Indicate type of service (CPT or HCPC code)
- Give date of service (anticipated start date and end date, if known)
- Indicate place of service (if hospital, include hospital name)
- Include contact name, phone number and fax number with area codes

Please use Blue e to check the status of your claims and allow 30-45 days before resubmitting claims.

It’s Important To Put Your Provider ID Number On Your Claims
Did you know that one of the top reasons that claims are mailed back is due to an incorrect provider number? Your provider number drives your payment. Making any of the mistakes listed below can result in significant payment delays, claims being mailed back, claims paid incorrectly, or claims paid to the wrong provider. Do your best to avoid these mistakes when submitting a claim:

- Provider number not listed on the claim.
- Provider number incorrect or invalid.
- Provider number transposed.
- Provider number not in effect for the date of service.
- Provider number has been terminated.
- Provider number listed in the incorrect field on the claim.

Are You Filing Coordination of Benefits Claims Correctly?
Maintaining and reporting accurate information regarding patients’ other coverage is critical to claims processing. If a member has other insurance (commercial or Medicare), and claims are filed to the SHP through the electronic 837 transaction, the primary carrier payment should be included with the submission. Otherwise, the claim will deny.

When a claim is filed to Medicare and you receive a Medicare Explanation of Benefits (MEOB) with reason code MA18 (the claim information is being forwarded to the patient’s secondary insurance), please do not submit a claim to the State Health Plan. Medicare will automatically forward the claim to us. Filing claims to the SHP when Medicare has already forwarded the claim to us creates duplicate claims submissions. Researching duplicate claims has a direct impact on our ability to process claims in a timely manner. If the claim has not been paid by the SHP within 30 to 45 days of receiving the MEOB, please check Blue e for payment status, and then submit a claim, if warranted.

The “other carrier field” on the claim form should only be used to report other coverage information. Placing information in this field, in the absence of other coverage, results in the claim pending for review and subsequent claim payment delays.

A Few Claim Filing Reminders
In an effort to process claims more efficiently, we have a few reminders to share with you:

- Corrected Claims – We receive a large volume of claims stamped “corrected claim” that are actually new claims. A corrected claim should only be submitted for a claim that has been paid or denied on your Notification of Payment (NOP) and for which you are making a correction. Stamping “corrected claim” on the claim form does not expedite processing.

(Continued on page 9)
State Health Plan Briefs (continued)

- **Ambulance Charges** – All ambulance claims must be submitted with a valid CPT code, modifier and mileage.

- **Emergency Room Services** - The onset date is required when filing emergency room services.

**How Far Back Will SHP Go For a Refund Request?**

The State Health Plan will no longer pursue any overpayments that exceed two years, unless the Claims Processing Contractor (CPC) or executive administrator of the State Health Plan deems that such a refund request is appropriate. This time frame is calculated by date of identification to date of payment and is for a standard refund request only. It does not apply to fraudulent, misuse or abusive filings. We will accept unsolicited provider refunds within any time frame.

**Prior Approval for Drugs**

The State Health Plan (SHP) now requires prior authorization for Pravachol (pravastatin) and Prevacid (lansoprazole), as of July 1, 2005. The State Health Plan encourages the use of less expensive drugs in these drug classes if they are clinically appropriate. Since most of the Proton Pump Inhibitors (PPIs) and cholesterol-lowering agents within the classes produce similar effects, the SHP-preferred medications should provide suitable alternatives and will be less expensive for members and for the SHP. Please consider prescribing these medications for your SHP patients.

### State Health Plan-Preferred Proton Pump Inhibitors (PPI)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prilosec OTC®</td>
<td>omeprazole (generic for Prilosec®)</td>
</tr>
<tr>
<td>Nexium®</td>
<td></td>
</tr>
<tr>
<td>Aciphex®</td>
<td></td>
</tr>
</tbody>
</table>

Please visit the SHP Web site at [statehealthplan.state.nc.us](http://statehealthplan.state.nc.us) for a complete list of prior authorization criteria summaries.

If one of the SHP-preferred alternatives is not right for the member or if greater than 90 days of a PPI is medically necessary, a coverage review will be required to determine if their specific circumstances meet the coverage conditions of the SHP. To request a coverage review, please provide additional information to the SHP by calling 1-800-753-2851, between the hours of 8:00 a.m. to 9:00 p.m., Monday through Friday.

SHP-preferred PPIs are covered for a three-month quantity limit per six-month period. Coverage for any PPI beyond a three-month supply per six-month period is only provided for severe/atypical GERD with related disorders, moderate GERD with daily/disabling symptoms having failed a 30-day trial of high-dose H2 blockers, or peptic ulcer disease, Barrett’s esophagus or hypersecretory conditions, or prevention of NSAID or steroid related ulcer.

Additionally, coverage for Prevacid is only provided in situations where the patient has experienced intolerance to all preferred PPIs. All prescriptions for Prevacid will require preauthorization according to these criteria.

Note that coverage for Prilosec OTC is provided by the SHP for a $5 copayment per 42-day supply if written on a prescription, requires no prior authorization, and is not subject to duration of therapy limits.

### State Health Plan-Preferred Statins

<table>
<thead>
<tr>
<th>Drug</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>lovastatin (generic for Mevacor®)</td>
<td></td>
</tr>
<tr>
<td>Lipitor®</td>
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<tr>
<td>Zocor®</td>
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</tr>
</tbody>
</table>

Coverage for Pravachol is only provided for patients who have exhibited intolerance (i.e., sensitivity, drug allergy, adverse effect or drug interactions) to all preferred statins.

**Claims Spanning the Fiscal Year**

*Please note: This is a correction to information that appeared in the summer 2005 Blue Link:

Providers are not required to split inpatient medical facility claims that pay based on Diagnosis Related Grouping (DRG) when they span the end of the fiscal year (July 1 through June 30). For all other inpatient claims, such as psychiatric, chemical dependency, rehabilitation, VA Hospital, skilled nursing facility, or when Medicare is the primary carrier, the claim will need to be split if the dates of service span the end of the fiscal year.
Communicate With BCBSNC Electronically

BCBSNC’s EDI Services provides you with support and development for the electronic transmission of all your communication needs:

- Filing claims
- Making eligibility or status inquiries
- Providing admission/treatment notification
- Receiving remittance information
- Reconciling your systems with electronic reports.

You can transmit multiple claims or inquiries in one batch at one time or submit single claims or inquiries via direct data entry, such as Blue e.

Electronic transmission of information offers tremendous improvements in cost-efficiency, accuracy and timeliness. You’ll receive immediate confirmation records that enable you to verify receipt and payment, or confirm that your patients have the coverage they need prior to treatment. Paper claims take time to get from your office to us through the postal system, have no receipt confirmation, and, when errors are contained in the claim, take longer to correct and resubmit.

If you would like to improve your office’s efficiency and account accuracy, speak with a BCBSNC EDI field consultant in your area about accessing all of the electronic services we have to offer.

Have You Got Your Patient’s Number?

As part of our adoption of the HIPAA security and privacy regulations, BCBSNC has initiated a program to remove Social Security numbers (SSN) as part of a member’s identification number. This program began last April and will continue throughout the year as new member identification cards are issued during the enrollment process. The nine digits of the member’s Social Security number will be replaced by a “W” and eight random digits (for example: W12345678). Prefixes and suffixes currently in use today will remain the same (for example: YPPW1234567801 would be the new number with the current prefix and suffix).

All electronic transactions (claims and inquiries) require the member’s identification number for processing. It is important that you review the member’s ID card at each visit to ensure that you have the patient’s new BCBSNC ID number in your systems. Your Notice of Payment (NOP) will reflect the identification number in use at the time of service.

Blue e News: Self Service for Password Reset

Have you ever locked yourself out of your Blue e account and had to call your help desk or EDI Customer Support to get back in? Soon you will be able to reset or change your password yourself. A new Password and Shared Secret Wizard takes you through the process step-by-step. Download the “Password Reset Job Aid” from the Blue e Home Help page for details about this new feature.

Medicaid Eligibility Changes

After September 2005, BCBSNC no longer houses Medicaid source records internally, as the Centers for Medicaid and Medicare Services (CMS) has restricted access to these records to their official vendor, Electronic Data Systems, Inc.(EDS), only. In order to maintain Blue e Medicaid eligibility inquiry functionality for our providers, BCBSNC transmits Blue e inquiries for Medicaid eligibility directly to EDS and returns the EDS response to our providers on Blue e using the standard HIPAA 270 and 271 transactions. In order to facilitate the new Medicaid Eligibility Inquiry, certain changes were made to the transaction. For example, the revised Medicaid eligibility transaction requires the Medicaid provider number.

For more details regarding changes made to the Blue e Medicaid eligibility transactions, see the Medicaid Eligibility Job Aid, which is posted on the Blue e Home Help page.

Admission Notification for BlueCard® Members

Blue e now allows hospitals to submit admission/treatment notifications for subscribers of Blue Cross and Blue Shield Plans in other states. New functionality offered by the Blue Cross and Blue Shield Association allows for easier sharing of information across the country about BCBS subscribers, no matter what state “Blue” Plan holds the policy.

A job-aid entitled BlueCard Access to Blue e Admission/Treatment Notification, providing instructions and details, is available from the Blue e Home Help page.

Batch Health Care Claims

Submit Secondary Claims Electronically

Secondary claims should be submitted electronically, but only after the primary claim has been processed. Primary claim information, which is returned to you after processing, is required for secondary claim submissions. Secondary claims submitted prior to the completion of the primary claim processing will not be processed.

Are Your Medicare Crossover Claims Failing?

If you are filing Medicare crossover claims prior to their primary payment, you are probably receiving notice of duplicate submission. Medicare crossover claims, like all secondary claims, must indicate that payment from Medicare has already occurred before filing, or they will be considered duplicates and not be filed.

(Continued on page 14)
To encourage tobacco cessation among our members, Blue Cross and Blue Shield of North Carolina recognizes the important role that providers play in advising and supporting patients in quitting. With that in mind, BCBSNC members who use tobacco are eligible to have coverage for office visits that are specifically scheduled to discuss tobacco cessation strategies and medications. Office visits for the treatment of tobacco use (ICD-9 code 305.1) with the appropriate level Evaluation and Management CPT codes are paid according to the fee schedule.

**Tobacco Cessation Counseling**

For more information about clinical, evidence-based tobacco cessation interventions, BCBSNC recommends TobaccoCME.com. This Web site has a unique, online training program for primary care health professionals on how to provide clinical tobacco interventions. Content is evidence-based and reviewed by tobacco-control experts from various medical and counseling fields, including primary care physicians.

These free courses provide comprehensive, high quality, respected curricula that cover the range of topics related to clinical tobacco interventions. A case-based format is used in some courses and interactive questions are used throughout all courses to better facilitate the transfer of knowledge to clinical skills. Resources include printable patient handouts, succinct clinical practice guides, related Internet links, counseling, resources, reimbursement information, reading lists, references, and information on how to order patient brochures and videos. Credits are available through CME, ACCME, CCME, AAFP, ACPE and NNBC. Again, to access the Web site, just go to TobaccoCME.com.

**Tobacco Free – A New Program for BCBSNC Members**

Tobacco Free is another example of BCBSNC’s commitment to preventive health care. We encourage our members to assume personal responsibility for their health, and we are dedicated to empowering and assisting them in reaching their goals.

BCBSNC offers members who use tobacco and are interested in quitting access to Tobacco Free, a program that provides information and resources to kick the habit. Members can request a Tobacco Free Quit Kit by going to bcbsnc.com and selecting “Tobacco Free” in our “Health and Wellness” section or by calling 1-800-218-5295.

The Tobacco Quit Kit includes includes contact information for a toll-free support line for one-on-one professional assistance from a certified tobacco-cessation counselor. The kit also includes instructions for accessing our Online Healthy Living Programs at bcbsnc.com, which are full of resources to support self-initiated efforts to quit tobacco use of any form, including discounts for over-the-counter nicotine replacement products. BCBSNC has already provided over 500 quit kits to members.

The program is available to all Blue Care, Blue Options and Blue Advantage members. However, patients who receive their health insurance through the Teachers' and State Employees' Comprehensive Major Medical Plan or the Federal Employee Program are not eligible. Also, the program is not available to members of self-funded groups who have chosen to exclude the Tobacco Free program from their benefits.

**Percutaneous Lumbar Discectomy**

Effective October 6, 2005, BCBSNC will no longer cover percutaneous lumbar discectomy (CPT code 62287). Previously, this CPT code was subject to prior Plan approval and was covered for patients who met specific criteria.

BCBSNC has reviewed this procedure and found a lack of scientific evidence to support the effectiveness of this procedure. BCBSNC medical directors, as well as a specialty matched consultant advisory panel, have reviewed the policy and unanimously agreed that the policy be changed to make percutaneous lumbar discectomy investigational.

This revised corporate medical policy will be effective and available for your reference on our Web site at bcbsnc.com on October 6, 2005. Please contact your local BCBSNC Network Management office if you have questions.
Medical Nutrition Therapy To Be Covered

Blue Cross and Blue Shield of North Carolina is expanding its provider networks statewide to include licensed, registered dietitians to provide medical nutrition therapy services to eligible members. Dietitians can provide on-one or group medical nutrition therapy.

Coverage for services provided by registered dietitians in our networks will be immediate for members diagnosed with diabetes. Effective October 1, 2005, as groups renew their coverage, the new benefit will be expanded to include Blue Care and Blue Options members who are actively enrolled in Healthy Lifestyle Choices℠, or in other BCBSNC programs under our Member Health Partnerships℠. In January 2006, coverage will be expanded to include Blue Advantage.

BCBSNC’s Member Health Partnerships include Healthy Lifestyle Choices (for weight management), and programs designed to educate and assist members with asthma, diabetes, heart disease, pregnancy, migraine, kidney disease, fibromyalgia and specialty care (rare conditions).

Six nutritional visits will be covered per year for members enrolled in a BCBSNC Member Health Partnerships program. Copayments will be waived for six visits per benefit period for services received from in-network providers providing office-based services. For services in a hospital setting, the member’s deductible and coinsurance may apply.

There is no limit on the number of visits for members with a diagnosis of diabetes. For members with diabetes who participate in a Member Health Partnerships program, their copayments will be waived for the first six visits after October 1, 2005, or their subsequent renewal. After six visits, members will be responsible for their copayment.

Member Health Partnerships - Specialty Care: Helping Members with Chronic, Progressive Diseases

Did you know that Blue Cross and Blue Shield of North Carolina offers a program for members with chronic, progressive diseases? Participants in this program will benefit from the following services:

- Personalized health evaluations and education from registered nurses and other health care professionals.
- Customized educational materials including brochures and monthly newsletters.
- Access to accordant.com, a patient Web site featuring in-depth, disease-specific information, live interactive events and additional resources.

Diseases covered by Member Health Partnerships - Specialty Care:

- Rheumatoid Arthritis
- Multiple Sclerosis
- Parkinson’s Disease
- Systemic Lupus Erythematosus (SLE)
- Myasthenia Gravis
- Sickle Cell Disease
- Cystic Fibrosis
- Hemophilia
- Scleroderma
- Polymyositis
- Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Amyotrophic Lateral Sclerosis (ALS)
- Dermatomyositis
- Gaucher Disease

To learn more about this program or to refer a BCBSNC-covered patient to the program, please call us at 1-800-218-5295.
Major Customer Service Improvements are Underway

We are pleased to announce that in spring 2006, our current touchtone telephone system will be replaced by a speech recognition system similar to those used by many banks and airlines. The technology will be implemented on most of our member and provider phone lines. The current phone numbers you use will not change. However, you will hear a new voice that asks short and simple questions to ensure that your call is routed accurately. Providers who participated in our initial tests report that the new system is faster, friendlier and more efficient.

Here is a sneak preview of some of the new features:

- The new speech recognition system will allow you to speak the subscriber ID number and date of birth for all members that you are calling about.
- It will sort the ID numbers, determine which representatives will need to assist you, and route you to the corresponding call center with the shortest wait time.
- Assuming that you have provided the information asked for by the speech recognition system, you will not have to repeat anything to the representative. He or she will be ready to assist you with your questions about the first member upon answering your call.

We will be developing a quick reference guide for providers to use to make the transition to the new system as smooth as possible. More details will be provided as we move closer to our implementation date this coming spring.

Four Ways to Get a Free Flu Shot

It’s almost flu season…again. All health care workers should be vaccinated against influenza annually. This will protect you, your patients, co-workers and even your communities. Physicians, nurses and other workers in both hospital and outpatient-care settings, including medical emergency-response workers (e.g., paramedics and emergency medical technicians), should be vaccinated, as should employees of nursing homes and chronic-care facilities who have contact with patients or residents.

Blue Cross and Blue Shield of North Carolina (BCBSNC) is offering four ways for members to get vaccinated free of charge this flu season. Here’s how:

1. Beginning October 1, BCBSNC will host regional flu shot clinics across the state for members who meet the CDC’s high-risk criteria. More information about the CDC’s high-risk guidelines is available at [cdc.gov/flu](http://cdc.gov/flu).

2. From October 25 through November 30, members can visit one of more than 700 pharmacies and grocery stores around the state that are offering free flu shots, while supplies last.

3. Take advantage of on-site clinics offered to employers with 100 or more BCBSNC-covered employees. Check with your employer to see if they will be hosting a free flu shot clinic this fall.

4. If their policies include preventive health benefits, most members can get flu shots from their physician at no charge. Unless an office visit is scheduled in addition to the flu shot, there will be no charge for the vaccination in most cases. Members should check their benefit booklet for more information about their preventive care benefits.

Nonmembers can receive a flu shot for $25 from any of the regional or retail clinics that will be held across the state this fall. And, the shots are free for Medicare Part B recipients. So, why take a chance? Get your flu shot this year and stay healthy.

To find the free flu shot location nearest you, call [1-866-534-7330](tel:1-866-534-7330) or visit [bcbsnc.com](http://bcbsnc.com).
Correct Your Professional and Institutional 837 Claims Electronically

Corrected 837 claims should be submitted electronically using one of the Frequency Type Codes in the 2300 loop, CLM05:3 element. Valid corrected claim codes are listed in the table below. Submitting corrected claims electronically improves turn-around time and relieves you of the need to file paper claims. Remember: Electronically corrected 837 claims do not need to be submitted on paper.

**Important Notice:** To verify that the original claim has been processed, check Blue e Claim Status for the status of the payment, or check your Notice of Payment (NOP) or Explanation of Payment (EOP) for a posting of the claim. The presence of the claim on the NOP or EOP ensures that it has been processed and can be corrected, if necessary.

<table>
<thead>
<tr>
<th>Value</th>
<th>Code Title</th>
<th>Definition</th>
</tr>
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</table>
| 5     | Late Charges Only | This code is to be used for submitting charges to the payer that were received by the provider after the Admit Through Discharge for the Last Interim Claim has been submitted.  
*Providers should not use this code in lieu of an Adjustment Claim or a Replacement Claim.* |
| 7     | Replacement of Prior Claim | This code is to be used when a specific bill has been issued for a specific provider, patient, payer, insured and “Statement Covers Period,” and it needs to be restated in its entirety, except for the same identify information. In using this code the payer is to operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill.  
*Providers should not use this code in lieu of a Late Charge(s) Only Claim.* |
| 8     | Void/Cancel of Prior Claim | This code reflects the elimination in its entirety of a previously submitted bill for a specific provider, patient, payer, insured and “Statement Covers Period” dates. The provider may wish to follow a void bill with a bill containing the correct information when a payer is unable to process a replacement to a prior claim. The appropriate frequency code must be used when submitting the new bill. |

*Note that Value 6 is no longer a valid code within the frequency type code set.*

Continuous Passive Motion in the Home Setting

Previously, Blue Cross and Blue Shield of North Carolina (BCBSNC) has reimbursed for continuous passive motion (CPM) devices for use in the “home setting” following some types of joint surgeries. Effective October 6, 2005, we will no longer cover CPM devices in the home setting. Coverage for use in a hospital setting will not change.

BCBSNC has reviewed the indications for these devices and based on an evidence-based approach, found a lack of literature focusing on the use of CPM outside of the acute hospital setting. External physician consultants and BCBSNC medical directors have reviewed the policy regarding the use of CPM in the home setting and support the change in our medical policy regarding CPMs. This corporate medical policy will be effective and available for your review on our Web site at [bcbsnc.com](http://bcbsnc.com) on October 6, 2005.

Orthopedists, durable medical equipment providers and other requesting providers for CPM devices will be notified by phone and/or in person by BCBSNC Network Management representatives of this policy change. Please contact your local BCBSNC Network Management office with questions.
Help Is Available for Fibromyalgia Patients

Imagine waking up in the morning feeling pain all over your body. Think about what it would be like to struggle to live a normal life because of severe, often burning, muscle pain.

This is what it is like to suffer from fibromyalgia, a chronic disorder associated with widespread muscle and soft tissue pain, tenderness and fatigue. Numerous studies have shown that fibromyalgia has a significant impact on the lives of those who suffer from it.

While there is no cure for fibromyalgia, most symptoms can be controlled through self-care methods at home. Fortunately, Blue Cross and Blue Shield of North Carolina has a program to help members who suffer from fibromyalgia learn how to reduce their symptoms and improve their quality of life.

Members who enroll in the Member Health Partnerships – Fibromyalgia program can receive:
- The most up-to-date information about treatment options for fibromyalgia.
- Personalized support from a specially trained nurse, any time day or night.
- Resources and tools that can help them work more effectively with their health care team.

Enrolling in the program is easy and free. Members can call 1-800-218-5295 or go online to bcbsnc.com and fill out the request form on the “Fibromyalgia” page, which is found in the “Health Management Tools” section. Please let your BCBSNC patients know that this confidential program is available to them free of charge.

Protecting Your Patients’ Health Care Needs

First, let us take a moment to define the term “corrected claim,” as there seems to be some confusion as to what exactly constitutes a corrected claim.

In order to be considered a corrected claim, the claim MUST be a previously processed claim. Please do not file a claim marked as corrected if you have not received a Notification of Payment (NOP) from us for the claim in question. Also, if you are changing the subscriber identification number on a claim, the claim must be submitted as a NEW claim and not as a corrected claim. Due to the change in subscriber identification numbers from Social Security-based numbers, we cannot adjust the original claim, so we will consider this one a new claim.

What is the Best Way to Submit a Corrected Claim?
- Corrected claims can be submitted electronically or on paper.
- If a corrected claim is submitted on paper, it often expedites the process if you will circle or highlight any changes.
- Institutional claims submitted electronically must have a corrected claims bill type noted. If you have not received a NOP, please do not file your claim with a corrected bill type. Instead, refile it with the original bill type as a new claim to us at:

BCBSNC Claims Department
P.O. Box 35
Durham, N.C. 27702

Claims not on filed with a corrected bill type will be mailed back for you to resubmit with the appropriate bill type.

Processing Time
We ask that providers allow us at least 30 days to process all corrected claims. Please note that duplicate submissions slow down the processing of true corrected claims. Again, if you have not received an NOP from us, please do not refile the claim as a corrected claim thinking that it will help to expedite the processing of the claim in question. Filing the new claim directly to us at the claims address will alleviate any unnecessary extra steps and will expedite the processing of the claim.

Bottom line, claims submitted as corrected claims in error slow down the processing of actual corrected claims. Submitting the primary carrier’s Explanation of Benefits (EOB) or attaching medical records with a copy of the claim is not a corrected claim if there is no change to the original claim. When medical records of EOBs are requested, please send that type of correspondence to us at:

BCBSNC Correspondence
P.O. Box 2291
Durham, N.C. 27702
BCBSNC Announces New HSA and HRA Products

BCBSNC is introducing two integrated products this fall, Blue Options HSA and Blue Options HRA, that combine a health plan with a savings account fund. BCBSNC will market Blue Options HSA and Blue Options HRA with January 1, 2006, effective dates.

Blue Options HSA
BCBSNC will offer to group and individual market segments new, high deductible health plans (HDHPs) that can qualify members to open a health savings account (HSA). In addition, BCBSNC has teamed with ACS HR Solutions, LLC and Mellon Trust of New England, NA, to offer integrated features such as enrollment into the HSA and access to the My HSA Account online account management tool. For members who choose to open an HSA with Mellon, Mellon will provide all of the fund management and administration features of the member’s HSA.

What Is an HSA?
A health savings account (HSA) is an account that members (or anyone on their behalf) can put money into to save for qualified medical expenses. HSAs offer many advantages to health care consumers not typically found in other health plans:

- Contributions are tax-deductible.
- Interest on HSA accounts is tax-free.
- HSA withdrawals can be used to pay for any qualified medical expense tax-free.
- Anyone can contribute to an individual’s HSA, including their employer.
- HSAs are portable. An individual owns the funds contained in his or her HSA, even if they switch jobs or health care coverage.
- Unspent balances roll over from year to year.

Blue Options HSA consists of a high deductible health plan, which will be administered by BCBSNC and can qualify an individual to open an HSA. A high deductible health plan is a federally defined health benefit design that qualifies someone to open an HSA. It’s important to note that because of the federal rules around these accounts, these plans will not have any copayments for services like office visits or prescription drugs.

The HDHP will offer members a PPO plan and Blue Options HSA members and their employers may contribute to an interest-bearing, FDIC-insured account – the Mellon HSA Solution – which they can use to pay for qualified medical expenses. Members will receive checks and a debit card to use for their qualified health care expenses.

Here’s how it typically works:
1. Members purchase a high deductible health plan that carries a lower premium than many other health plans.
2. Members and their employers can contribute to an HSA to cover their qualified medical expenses up to the amount of their deductible each year or the allowed limit.
3. When members use health care services, their physician or hospital files a claim with BCBSNC.
4. BCBSNC processes the claim, taking into account BCBSNC’s negotiated fees and how much the member has paid toward his or her deductible. BCBSNC sends this information to the member and the physician/hospital, along with any payment due on the claim.
5. The physician/hospital bills the member for the amount that he or she owes.
6. The member pays the provider’s bill with funds from his or her HSA, using a check from their HSA account or HSA debit card, or using other personal fund sources as they do today.

An HSA account functions much like an IRA for medical care. When a member’s account reaches a minimum balance, the member may invest additional contributions in a selection of mutual funds available through The Dreyfus Corporation.

For more information about HSAs, go to treas.gov or visit BCBSNC’s Web site at bcbsnc.com.

Blue Options HRA
BCBSNC will offer employer groups similar benefit designs as HDHPs that employers can offer along with a health reimbursement account (HRA). In addition, if the employer selects BCBSNC’s suggested HRA administrator, Select Data Service Administrators, Inc. (SDSA), as their HRA administrator, the employer and employee are offered integrated features such as enrollment into the HRA and access to My HRA Account online account management tool. SDSA will provide all of the financial and administrative features of the HRA.

What Is an HRA?
A health reimbursement account (HRA) is an account that employers put money into for members to use for qualified medical expenses. Employers determine contribution amounts and establish rules regarding account use and portability.

Blue Options HRA consists of an HDHP (a PPO plan) and an HRA. The HDHP will be administered by BCBSNC, while the HRA will be offered through a relationship with Select Data Service Administrators, Inc (SDSA).
HRAs differ from HSAs in that the employer has more control over the use of the funds and rollover rules. In addition, HRAs do not include interest or investment options. Employers will have the option to offer members a debit card to access their HRA funds.

To Find Out More
These health savings accounts and health reimbursement accounts products provide BCBSNC an opportunity to offer innovative options to members and employers. These fund-based products are an important part of the “consumerism” focus in the health care market.

Blue Options HSA and Blue Options HRA are both included under BCBSNC’s Blue Options/PPO network. For questions about the launch of these new product offerings, please contact your local Network Management field office.

BCBSNC Provider Collections Policy for Blue Options Deductible and Coinsurance-Only Products

As mentioned in the previous article in this issue, BCBSNC will be introducing Blue Options HSA and Blue Options HRA products to our customers January 1, 2006. These are high deductible health plan (HDHP) products that do not have copayments. They are deductible and coinsurance plans with some preventive care options and will present a different collecting environment for you, the provider.

In the past, BCBSNC’s policy for all products was that participating providers should not collect upfront funds from the member (other than copayments) until the Explanation of Payment was received from BCBSNC indicating the correct amount to be collected. This policy is being altered for Blue Options HSA and Blue Options HRA products. And in order to provide you with a consistent collection policy, it will also apply to all Blue Options noncopayment products and plans. This serves as notice of the new policy for Blue Options deductible and coinsurance-only products.

New Collection Policy Statement
For any Blue Options deductible and coinsurance-only product (not copayment products), BCBSNC in-network providers (including physicians, professional providers, hospitals and ancillary providers), may collect an estimated amount from members at the time of service for a member’s out-of-pocket costs, as described below.

To determine whether a product is covered under this policy, all providers should check the member ID card to make sure that both of the following criteria are met:

- Make sure that the card indicates a coinsurance amount for physician services. If so, it is a deductible and coinsurance-only product. If the card indicates a copayment for physician services, the product is not subject to this policy and no estimated amounts should be collected for any service by any provider.

- Make sure that the card indicates that the product is a Blue Options product (including Blue Options HRA and Blue Options HSA). If the card does not indicate Blue Options, it is not subject to this policy and no estimated amounts should be collected.

In all cases, in-network hospitals and providers are required to check for a member’s remaining deductible or coinsurance amounts using sources such as RealMed, Blue e, or BCBSNC Customer Service. Keep in mind that these sources provide the most accurate information available at the time, as the information provided on the Explanation of Payment (EOP) from BCBSNC may differ based on claims that were in transit to BCBSNC or any applicable adjustments.

The limitations on collection of estimated amounts are as follows:

- **Physicians or professional providers** may collect up to the lesser of the member’s estimated out-of-pocket costs or $50 for services received in the provider’s office, including services rendered in a hospital-owned clinic.

- **Hospitals and ancillary providers** may collect up to the lesser of the member’s estimated out-of-pocket costs or $500 for services received in a hospital or outpatient facility such as an emergency room or ambulatory surgery center.

Providers must inform the member that the amount being collected is an estimate. Providers must also calculate the member’s out-of-pocket costs based on the lesser of the allowed (contract) amount or billed charges, taking into account the member’s benefit year-to-date deductible or coinsurance benefit status (amount met). The final determination of what the member owes will be based on the claim that is submitted to BCBSNC, and will be reflected on the EOP. Any applicable refunds due to the member must be returned within 45 days. If a member is

(continued on page 18)
unable to pay at the time of service, the provider should not refuse to provide necessary treatment to the member.

If they choose (and if funds are available), the member can use funds from their HSA or HRA to pay for these services. The provider should be aware of the tax implications if funds are withdrawn for nonqualified medical expenses or for expenses that the member did not incur, without subsequent and timely correction by the member. The member will need to take responsibility for correcting any incorrect withdrawals. Therefore, if your estimated collection was too high, and you are aware that the member used an HRA or HSA fund, you should remind the member to make the appropriate correction.

We’ll share more details about the launch of these new products and available provider resources for determining member liability amounts in future issues of Blue Link.

**Again, please note that the current policy for the collection of copayments, deductibles and coinsurance amounts for those members enrolled in copayment products and non-Blue Options products has not changed.**

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**Consistency for Prior Plan Approval**

On July 1, 2005, BCBSNC moved medical necessity reviews for certain outpatient services from the retrospective review category to the prospective review (prior Plan approval) category for Blue Advantage and Blue Options (excluding the State Health Plan or the Federal Employee Program) members. This change was made to create consistency in the administration of benefits across our lines of business.

Here is a list of BCBSNC's prior Plan approval services, including the outpatient services that were moved to prospective review. This list is subject to change once per quarter. **If changes are made to the prior Plan approval list, our Web site at bcbsnc.com will be updated by the 10th day of January, April, July and October.** To access the prior Plan approval list, select the “I'm a Provider” page and choose the “Prior Authorization” category. You can also contact Medical Resource Management (MRM) at 1-800-672-7897 for a list of services requiring prior approval. In addition, our Internet-based application, Blue e, will be updated whenever changes are made to the prior Plan approval list.

The process for obtaining prior Plan approval has not change. You can still request an approval by calling, faxing or mailing your request to us at:

**Medical Resource Management Department**
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291
Durham, NC 27702

Toll-Free Number: ............................ 1-800-672-7897
Region 1 Fax Number: ......................... 1-800-459-1410
Region 2 Fax Number: ......................... 1-800-571-7942
Region 3 Fax Number: ......................... 1-800-672-6587
Discharge Services Fax Number: .......... 1-800-228-0838

(continued on page 19)
### Blue Advantage® and Blue Options℠ Prior Plan Approval List*

#### General Services Already Requiring Prior Plan Approval for Blue Advantage and Blue Options

**Inpatient admissions:**
- The Plan should be notified of urgent/emergent admissions by the second business day of the admission.
- Maternity admissions related to delivery do not require pre-admission certification for the first 48 hours for vaginal delivery or the first 96 hours for c-section. Inpatient stays beyond the first 48 hours for vaginal delivery or the first 96 hours for c-section require authorization.
- Any other elective/scheduled admissions must be approved prior to admission.

**Private duty nursing**

**Skilled nursing facility (SNF) and acute rehab**

**Transplants** – solid organ or bone marrow/stem cell

**Mental Health/Substance Abuse Treatment (currently applies to Blue Options only)**
- Excludes office visits
- Contact the vendor at the phone number on the BCBSNC ID card

#### Certain prescription drugs (currently applies to Blue Options only)**

### Consistency for Prior Plan Approval (continued from page 18)

#### Outpatient Services Added to Prior Plan Approval List for Blue Advantage and Blue Options

**Effective for service dates on or after 7/1/05**

**Out- of- Network/Nonparticipating Services**

The Plan may authorize out-of-network/nonparticipating services at the in-network benefit level if a service is not available in-network or if there is a transition of care issue.

**Non-Emergent Ambulance and Air Ambulance Services**

**Durable Medical Equipment** - Specific codes are available from BCBSNC Customer Service, Medical Resource Management or your Network Management representative.

**Home Health Services, including nursing and home infusion**

**Surgery and/or Outpatient Procedures, such as:**
- Lung volume reduction surgery
- Morbid obesity surgery
- Orthotripsy

**Procedures Potentially Cosmetic, such as:**
- Reconstructive surgery, including but not limited to rhiotidectomy, dermabration, scar revision
- Breast surgeries including insertion and removal of silicone breast implants (not resulting from mastectomy), reduction mammoplasty, and gynecomastia
- Otoplasty
- Blepharoplasty

- Percutaneous treatment of HNP
- UPPP, surgical management of obstructive sleep apnea
- Vertebroplasty and Kyphoplasty

- Abdominoplasty
- Therapy of superficial veins, such as varicose veins, telangiectasias
- Home use of ultraviolet light box
- Orthognathic surgery
- Rhinoplasty

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*This list is subject to change each quarter (by the 10th day of January, April, July and October). The most current PPA list can be found on our Web site at [bcbsnc.com](http://bcbsnc.com).

**The lists for prescription drugs that require prior approval or are subject to quantity limitations also can be found on our Web site.
NCTars: North Carolina Taking Antibiotic Resistance Seriously

The North Carolina Division of Public Health in partnership with Wake Forest University School of Medicine is launching a statewide education initiative to combat antimicrobial resistance.

The program is called “NCTars North Carolina Taking Antibiotic Resistance Seriously,” and has two main objectives:

- Educate the community about antibiotic resistance and how it relates to antibiotic use.
- Educate physicians and other health care providers about the prudent use of antibiotics.

Physician education on appropriate treatments of upper respiratory tract infections, which are predominately caused by viruses, is crucial to appropriate antibiotic use.

For more information about antimicrobial resistance and its prevention, the Centers for Disease Control and Prevention (CDC) has information and patient education materials available at [cdc.gov/drugresistance](http://cdc.gov/drugresistance).

For more information about the NCTars educational campaign, contact Michelle Wallis at 1-336-716-6342.